ENGLEWOOD CLIFFS SURGERY CENTER *an affiliate of* **SCA**

910 Sylvan Avenue, Englewood Cliffs, NJ 07632 201-500-6440

ID / Visit: /

DATE	TIME IN	LAST NAME	FIRST NAME	M.I.	DEPOSIT	ATTACHMENT	C.I.

M/F	DOB	AGE	MSW	HOME PHONE	RIDE/PHONE	NEED TO CALL	WILL BE HERE

ADDRESS	STREET	CITY	COUNTY	STATE	ZIP

PRIOR ADMIT	SSN	DRIVER LICENSE	OCCUPATION	WORK PHONE

RESPONSIBLE PARTY NAME AND ADDRESS IF DIFFERENT FROM ABOVE	Email

RELATION TO RESPONSIBLE PARTY	RESPONSIBLE PARTY SSN	RESPONSIBLE PARTY EMPLOYER	RESPONSIBLE PARTY PHONE

PRIMARY INS. CO. NAME/NAME OF INSURED	SECONDARY INS. CO. NAME/NAME OF INSURED

I.D. .#/SSN	GROUP#	AUTHORIZATION	I.D. .#/SSN	GROUP#	AUTHORIZATION

INSURED'S EMPLOYER AND PHONE	INSURED'S EMPLOYER AND PHONE

SURGEON	DOI	CLAIM#	ATTENTION

DIAGNOSIS

PROPOSED SURGERY

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I hereby assign to and authorize payment directly to the facility named above (the "facility") of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility. I further assign and authorize direct payment to physicians providing services at the facility of all insurance benefits payable under the terms of any insurance policy for the services and medical treatment rendered by physicians who are authorized to bill.

A photostatic copy of this agreement shall be considered effective and valid as the original.

I irrevocably agree that the facility may disclose, to the extent allowed by the law, my medical and financial record to (a) any affiliate of the facility, specifically including Surgical Care Affiliates and its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, or any person or entity responsible for all or part of the facility's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Centers for Medicare and Medicaid Services, any other governmental or accrediting agency, or their agents and employees.

Information Privacy: This surgery center will use and disclose your personal information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payor. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payor as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amounts when and as due.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

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DIAGNOSIS

PROPOSED SURGERY

ADVANCED DIRECTIVE/LIVING WILL/HEALTH CARE PROXY

I understand I have the right to make choices regarding life-sustaining treatment (including resuscitative-measures) and will check all boxes that apply to me:

☐ Yes, I have provided the Facility with a copy of my Advance Directive/Living Will/Health Care Proxy. The facility has explained to me their policy that if an adverse event occurs during my stay, based on reasons of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measures and I agree to proceed with the proposed procedure as scheduled.

☐ I have an Advance Directive/Living Will/Health Care Proxy, but I have not provided the facility a copy. The facility has explained to me their policy that if an adverse event occurs during my stay, based on reasons of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measures and I agree to proceed with the proposed procedure as scheduled.

☐ I do not have an Advance Directive/Living Will/Health Care Proxy. The facility has explained to me their policy that if an adverse event occurs during my stay, based on reasons of conscience, all reasonable efforts will be taken to revive me, including resuscitative or other stabilizing measures and I agree to proceed with the proposed procedure as scheduled.

☐ I wish to have information on how I can obtain an Advance Directive/Living Will/Health Care Proxy.

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ID / Visit: /

PATIENT NAME				ACCOUNT RECORD	DATE
PROPOSED PROCEDURES					
REFERRING M.D.	DATE OF BIRTH	AGE	SEX	SURGEON	

Consent to Cell Phone Calls for Procedure/Financial Communications:

With regards to services rendered and/or my related financial obligations, I expressly agree and consent that the ASC facility and any associated affiliate / vendor providing quality improvement, customer service, billing or collection services may contact me by any method of contact (such as a telephone call utilizing an automated dialing device, dialing services, prerecorded message, texting or emailing) to any telephonic number that I have provided to the surgery center, or has been obtained by the surgery center or any of its associated affiliates / vendors or at a number forwarded or transferred from that number, including mobile telephone numbers. Messages may include my name, the name of the medical practice and/or any relevant billing agents.

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- **Notice of Privacy Practices:** I acknowledge receipt of the Notice of Privacy Practices and understand that it outlines how Precision Surgery Center may use and disclose protected health information.
- **Patient Rights and Responsibilities:** I acknowledge receiving a copy of the Surgical Care Affiliates Patient Rights and Responsibilities, and I understand that both Precision Surgery Center of Englewood Cliffs and I, as the patient, mutually agree to the rights and responsibilities outlined.
- **No Surprise Act:** I acknowledge receipt of information regarding the No Surprises Act and understand my rights under this legislation.
- **HIPAA Disclosure:** I confirm that I have been provided with information about my rights under HIPAA (Health Insurance Portability and Accountability Act) and understand how my personal health information will be handled and protected.
- **Disclosure of Financial Interest:** I acknowledge receipt of the Disclosure of Financial Interest and confirm that I received this information prior to my scheduled procedure or surgery.
- **Non- Discrimination in Treatment of Patients/Limited English Proficiency (LEP):** I have received a copy of the Surgical Care Affiliates Non-Discrimination Policy and Limited English Proficiency (LEP) Notice.

Furthermore, I understand that this information is provided for my benefit, and should I have any questions regarding its content, I should contact Precision Surgery Center of Englewood Cliffs for clarification.