7589 PRESTON RD., SUITE 100
FRISCO, TX 75034
(214) 387-4100

PRIVACY NOTICE: I have been given a copy of the HIPAA Privacy Notice. I also understand a copy of the HIPAA Privacy Notice is posted in the lobby for review.

CONSENT TO DRAW BLOOD/ EMERGENCY PROCEDURES: I hereby consent to the withdrawal of a blood sample in the event an employee or contractor of the Surgery Center had a needle stick or mucous membrane exposure to my blood or bodily fluids. I further consent to medical treatment from a licensed physician in the event of a highly urgent or emergency event in which the patient, a family member or other responsible party cannot reasonably be reached to authorize treatment.

RELEASE OF INFORMATION: In general, medical information concerning the patient's procedure is treated as confidential by the Surgery Center, its personnel and members of its medical staff. I authorize the Surgery Center to release any information necessary for the purpose of determining coverage to my insurer or the entity responsible for claims payments without my further written consent.

FINANCIAL AGREEMENT & ASSIGNMENT OF INSURANCE BENEFITS: In consideration for the services rendered to the above-named patient, the undersigned hereby individually obligates him/herself to the account of the accordance with the Surgery Center's regular rates and terms regardless of whether insurance payments are available or made on my behalf. In the event it should be necessary to refer the account to any attorney or collection agency for collection, I hereby agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts, at the Surgery Center's option, bear interest at the legal rate.

In consideration of services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits to the above-named Surgery Center, otherwise payable to me for this admission. I transfer and assign all rights, title and interest in the above-named insurance policy, any payment due me to the above-named Surgery Center. I understand and agree that I am responsible for providing any information required by my insurance company and agree to follow those pre-admission and pre-authorization guidelines which the insurance company may require. I understand that I am financially responsible for all changes which are not covered by insurance, including, but not limited to, co-pays, deductibles, charges in excess of policy coverage, and limitations or exclusions of coverage. In the event my claims are denied, require reconsideration, or an appeal for payment, I authorize the above facility to file an appeal with my insurance carrier on my behalf.

PERSONAL VALUABLES & MEDICATION: It is understood and agreed that the Surgery Center will not be liable for any loss or damage to valuables, including, but not limited to, money, jewelry, glasses, dentures, fur items, documents, canes, or personal medical equipment or supplies, clothing, shoes or other apparel. It is understood and agreed that I will not bring or consume personal medications without the Surgery Center's notice of written permission from my attending physician and that the Surgery Center will not be liable for any harm incurred thereby.

ADVANCE DIRECTIVES: I understand that the Surgery Center will not honor an Advance Directive and will not be liable for its terms. The Surgery Center offered information to me regarding the state law for Advance Directives. Do you have an Advance Directive? **Yes** ☐ **No** ☐ Did you bring a copy? **Yes** ☐ **No** ☐

CMS COMPLIANCE: I did receive a copy of Patient Rights, Responsibilities, and Grievance policy before admission to the Surgery Center upon registration at the counter.

PHYSICIAN: In consideration of medical or surgical services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits due to me to the physicians named below. I transfer and assign all right, title and interest in the above-named insurance policy any payments due for physician medical/surgical services to:

Physician: _____ Anesthesiologist: _____

☐ Your physician has financial interest in the Surgery Center

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I AM EITHER THE PATIENT, PARENT, LEGAL GUARDIAN OR AM DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. I UNDERSTAND AND AGREE THAT, AT THE TIME THE PATIENT HAS MET THE SURGERY CENTER'S MEDICAL CRITERIA TO LEAVE THE FACILITY. I WILL HAVE A RESPONSIBLE ADULT PRESENT TO TAKE ME/PATIENT HOME. I RELEASE THE SURGERY CENTER FROM ANY RESPONSIBILITY FOR EVENTS IN VIOLATION OF THIS AGREEMENT.

_____	_____	_____	_____
Patient's Signature	Witness	Date	_____AM/PM Time

_____	_____	_____	_____
Patient's Representative	Relationship to Patient		