North Metro Surgery Center

MULTIPLE AUTHORIZATION FORM

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's and/or anesthesia charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center, physician's office, anesthesia and/or pathology providers are not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. I am aware that I may receive a separate bill should there be any pathology performed from the pathology companies.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to North Metro Surgical Center, my admitting physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third-party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS AND OTHER PROTECTED HEALTH INFORMATION

I authorize the Center, my admitting physician and other physicians who provide services to me to use and disclose all or part of my medical records and other protected health information (known as "PHI") to treat me, to obtain payment for services provided to me, including when required to submit an insurance claim for payment of services, and to operate the Center including for accreditation, licensure, regulatory oversight, quality assurance and legal purposes and to individuals or entities that provide services to the Center and agree to safeguard PHI . I authorize the Center to disclose discharge instructions and PHI related to my care to family members or friends involved in my care, including the individual driving me home from a procedure or who I identify as assisting in my post-procedure care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at North Metro Surgical Center may have an ownership interest in North Metro Surgical Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at North Metro Surgical Center.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my demographic and insurance information on this date and verify that all information reported to the center is correct.

EMAIL/TEXT/AUTOMATED COMMUNICATION INFORMED CONSENT

I hereby consent and authorize North Metro Surgery Center, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

PATIENT RIGHTS/ADVANCE DIRECTIVES INFORMATION

I have been offered written and been given verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

I hereby acknowledge that a copy of the Notice of Privacy Practices for North Metro Surgery Center has been made available to me. I have the right to obtain a paper copy upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

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MULTIPLE AUTHORIZATION FORM

X_____ _____ _____

Signature of Patient or Responsible Party **Print Name** **Date Signed**

* Relationship to Patient: ❑ Power of Attorney ❑ Parent or Legal Guardian