**Brandon Ambulatory Surgery Center**
**Financial Agreement**

**Patient Name:_____ Date of Surgery: _____**
**My Surgeon is: _____ Type of Surgery: _____**

**How can we reach you?**
**Cell phone: _____ Home Phone: _____**

**Work Phone: _____ Email Address: _____**

**Please attach the following:** Patient ID Sticker

**☐ I have included a copy of my driver's license or other ID**
**☐ I have included a copy of my insurance card (front and back)**

***Please initial each area:***

**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 has a needle stick or mucous membrane exposure to my blood or body fluids. I further consent to medical treatment from a licensed physician in the event of a highly emergent or emergency event in which the patient, a family member or other responsible party cannot reasonably be reached to authorize treatment.
**INITALS_____**

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

**FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS**

I accept responsibility to ensure that all services are paid in full within 60 days according to the following guidelines: **Initials _____**

In consideration for the services rendered to the above-named patient, the undersigned hereby individually obligates himself/herself to the account of the Surgery Center in 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, will bear interest at the legal rate.
**INITALS_____**

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 charges, which are not covered by insurance, including, but not limited to, co-pays, deductibles, charges in excess of policy coverage, and limitations or exclusive of coverage.
**INITALS_____**

**PERSONAL VALUABLES AND MEDICATIONS**
It is understood and agreed that the Surgery Center will not be liable for any loss or damages to valuables, including, but not limited to, money, jewelry, glasses, dentures, for 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.
**INITALS_____**

**HIPAA (Health Insurance and Portability and Accountability Act)** (please circle YES or NO)
HIPAA policy available on request and copy located in the lobby of Brandon Ambulatory Surgery Center:

- OK to call my home: YES NO (list alternate method to contact) _____)
- OK to leave a voice message:
  - With Machine: YES NO
  - With Spouse/ Significant Other: YES NO
  - With other person: YES NO (Please list) _____
- OK to discuss information regarding my procedure with (list)
  _____
- Ok to share medical information with the following: YES NO
  - Surgeon, Insurance Company, Anesthesia Providers, Laboratory Services, Radiology Services, Federal, State and Local regulatory agencies, Peer Review, committees for Performance Improvement of BASC

**I understand and agree that, at the time the patient has met the Surgery Center's medical criteria to leave the center, 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.**

**Name: _____ will be driving the patient home after discharged from the center.**

☐ **Driver will remain at the center during surgical procedure.**

☐ **Driver will be leaving the facility during the procedure and can be reached at: _____**

**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.**

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

_____ _____
Patient Representative Relationship to Patient