Delaware Surgery Center, LLC
200 Banning Street, Ste 110
Dover, DE 19904

302-346-4000 Phone
302-741-2279 Fax

SURGERY CENTER ADMISSION

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesiologist, CRNA, physicians assistant, and pathologist are independent contractors and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to explain the nature of the services being provided and to obtain the patient's informed consent for all surgical procedures. Any questions concerning the surgery/procedure or results of any examination or treatment should be directed to the patient's physician.

Initial: _____

PROFESSIONAL SERVICES: The patient will receive professional services from their surgeon and may also receive services from other healthcare professionals while at the center. This includes physician assistants, anesthesia providers and pathology/laboratory personnel required to obtain a final diagnosis. These services are billed separately by those individual physicians and/or laboratories. Other providers may not have a contract with the covered person's health carrier and may be considered to be out-of-network. In such instances services that are provided on an out-of-network basis may result in additional charges for which the covered person may be responsible. In addition, the patient is responsible for any coinsurance, deductibles, and copayments applicable under the patient's health insurance contract.

Initial: _____

PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property brought by patient to the surgery center, including but not limited to money, jewelry, documents, dentures, eye glasses or any other articles. **Initial: _____**

NOTIFICATION OF PHYSICIAN OWNERSHIP IN SURGERY CENTER: I understand that my physician may be an owner of the Delaware Surgery Center. I understand that I have the option to choose another facility in which to receive the services that have been ordered by my physician. **Initial: _____**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND FINANCIAL RESPONSABILITY:

I authorize the Delaware Surgery Center to obtain or release reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with my referring doctor, the doctor requesting consultation, my family physician(s), as well as any other healthcare providers, hospital or outpatient facilities that I have or will identify with you. This information may be necessary to obtain so that the Surgery Center can conduct quality assessment and improvement activities related to peer review, and/or outcomes evaluation related to the event or hospital transfer.

I agree to the extent necessary to determine liability for payment and to obtain reimbursement that the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or workers' compensation carriers). Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-payments owed at the time of services. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law. I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any other payer is correct. I assigned to the Surgery Center, all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services. I authorize payment of medical benefits to the surgery center for the services provided. **Initial: _____**

ADVANCE DIRECTIVE/LIVING WILL: The Delaware Surgery Center, LLC is an outpatient surgery center where only elective procedures are performed. Therefore, we do not honor Advance Directives, and all patients are presumed as having consented to full resuscitated measures when signing the consent for surgery. The following Advance Directive Notification Policy has been instituted by Delaware Surgery Center, in accordance with state laws and Federal ASC Regulation (42 C.F.R. 416.509(a) (2)). Patients are not required to have an Advance Directive; however, an inquiry will be made to patients during the preoperative anesthesia interview as to whether they have an Advance Directive. If the patient has an Advance Directive, a request for a copy will be made and placed on the medical record the day of surgery, when provided. In the event of a life threatening situation, emergency measures/resuscitation will be initiated, the patient will be treated, and transferred to a higher level of care, as necessary. In the event of a hospital transfer, a copy of the patient's chart and Advance Directive will be sent with the patient.

The official State of Delaware Advance Directive form is available upon request, or can be downloaded at:**www.dhss.delaware.gov/dsaapd/advance1.html** **Initial: _____**

PATIENT PRIVACY, RIGHTS AND RESPONSIBILITIES: I understand that Delaware Surgery Center (the "Center") is a provider of health care, and that it may share my health information for treatment, billing and healthcare operations. I have been given a copy of the Center's Notice of Privacy Practices that describes how my health information is used and shared.

I realize that I have the right to review the Notice before signing this form. As stated in the Notice, the terms of the Notice may change, but we reserve the right to change the terms of this Notice, and to make the revised Notice effective for health information we already have about you as well as information we receive in the future. If any important provision of the Notice of Privacy Practices is changed, a revised copy of the Notice will be provided to me at the time of my next appointment.

I can contact the Center's Privacy Officer, Jennifer Anderson at 302-736-3710, if I have any questions about this Notice.

1. HIPAA Privacy Notice and Patient Bill of Rights

   ☐ I have declined a copy

   ☐ I have received a copy

2. May we leave a message concerning condition/result and information pertaining to postoperative phone calls?

   ☐ Yes

   ☐ No

3. You may discuss my condition/results with: _____ Relationship: _____

By signing this form, I hereby acknowledge and understand all the above statements.

Name (Print): _____

Signature: _____ Date: _____

☐ Patient ☐ Legal Representation; relationship to patient: _____

FOR USE BY DELAWARE SURGERY CENTER, LLC ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:_____

_____

_____

Signature of Delaware Surgery Center, LLC representative: _____ Date: _____

Printed Name _____