Surgery Center of South Central KS

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Surgery Center of South Central KS (Center) and/or physician's 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 and or physician's office is 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.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to the Surgery Center of South Central KS, 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

I authorize the Center, my admitting physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at the Surgery Center of South Central KS may have an ownership interest in the Center. The Center's physician owners are Dr. Rettig, Dr. Strange, and Dr. Wellemeyer. 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 the Surgery Center of South Central KS.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information prior to the date of service and verified that all information reported to the Center is correct.

Email/Text/Automated Communication Informed Consent

I hereby consent and authorize the Surgery Center of South Central KS, 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.

To revoke your consent to receive text messages or electronic mail from the Center, reply and enter "Unsubscribe." If you would like to revoke other portions of this Consent, please contact the Center directly in writing or by telephone.

TREATMENT AUTHORIZATION

In the event that a health care worker is suspected to have been exposed to my blood or body fluids or in the event that my illness requires such care that health care worker exposure to my blood and body fluids is likely, I consent to have the above providers(s) determine by serological testing whether or not my blood contained contagious viruses. I understand that information obtained from such tests will only be exposed as necessary to adequately protect my own health and the health of my family, as well as the health care personnel who may become involved in my treatment.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

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

☐ **Patient brought copy of Advanced Directive**

NOTICE OF PRIVACY PRACTICES

I have received notification of the Center's privacy practices. I have been offered a paper copy of the current version of the Notice.

X_____ _____ _____

Signature of Patient or Responsible Party | Date | Signature of Guardian/Responsible Party

X_____ _____

Witness | Date