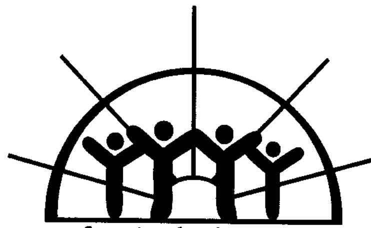


Center for Ambulatory Surgery
550 Orchard Park Road, West Seneca, NY 14224
Phone: (716) 677-4400 Fax: (716) 677-4163

CONSENT FOR CARE & TREATMENT AND PAYMENT AGREEMENT

AUTHORIZATION FOR CARE & TREATMENT: I hereby grant permission to Center for Ambulatory Surgery to perform care and treatment, and conduct examinations, laboratory tests and procedures, administer local anesthetics, medication and treatment, as may be directed by my physician or treating practitioner. I acknowledge that no guarantees have been made to me as to the effect of such examinations, tests, procedures or treatment of my condition.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I consent to the use and disclosure of my Protected Health Information by Center for Ambulatory Surgery for purposes of treatment, payment and health care operations. For example, my attending physician or treating practitioner at Center for Ambulatory Surgery may furnish Protected Health Information maintained by Center for Ambulatory Surgery in the course of my care and treatment. Release of medical records and information will be made according to state and federal regulations. I understand that Center for Ambulatory Surgery may release medical information to any third party, including my employer, which may be responsible for payment of my medical expenses. (Release of medical information to employers is limited to those employers who are directly liable for the cost of the patient's health care benefits through an employer, self-insured group health plan or worker's compensation, or in circumstances in which such disclosure is legally allowed.)

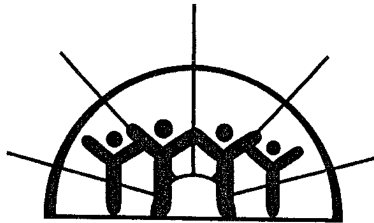
INSURANCE AUTHORIZATION: I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain services in order for my insurance company to pay for those services. I also understand that I may be personally responsible for payment if I do not obtain any necessary prior authorization or my insurance benefits are denied, reduced or terminated.

ASSIGNMENT OF BENEFITS, INSURANCE PROCEEDS, SETTLEMENTS: If I am entitled to health care services under any insurance policy from any person or organization which may become liable to me to provide such benefits, I assign such benefits to Center for Ambulatory Surgery for services rendered to me. I further authorize payment directly to Center for Ambulatory Surgery of all such insurance benefits payable to me. Such insurance may include, but is not limited to, private commercial insurance, auto liability insurance, worker's compensation, programs such as Medicare and Medicaid, or other governmental sources.

I certify that the information given regarding my insurance is accurate and correct to the best of my knowledge.

I further assign to Center for Ambulatory Surgery any payment for medical benefits payable to me as a result of any settlement or judgment in a lawsuit.

CERTIFICATION OF MEDICARE BENEFITS TO CENTER: (Applicable to Medicare beneficiaries only) I hereby authorize Center for Ambulatory Surgery to bill Medicare and receive payment on my behalf for any authorized Medicare benefits for services furnished to me by Center for Ambulatory Surgery. I certify that the information given by me in applying for such payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information or other information about me to release in to Medicare or its agents, as necessary, for payment of this, or any related Medicare claim.



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CONSENT FOR CARE & TREATMENT AND PAYMENT AGREEMENT (cont.)

FINANCIAL AGREEMENT: In consideration for services rendered by Center for Ambulatory Surgery, I guarantee prompt payment of all such services not paid by insurance carriers or third parties within thirty (30) days. I understand that any amount not covered by my insurance carrier or other third party payer is my personal responsibility, and I agree to make payment for any such amounts. If Center for Ambulatory Surgery does not receive such payment within thirty (30) days from the date such balance is due, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collection costs including attorney's fees and/or collection fees in addition to the payment owed. I give the facility the right to examine my consumer credit report for financial information relating to my responsibility to pay for medical services. I understand that, in most cases, my attending physicians, anesthesiologist and other consultants and/or surgeons at Center of Ambulatory Surgery are independent practitioners, and not facility employees. I will receive a separate bill from them for their services.

RELEASE OF LIABILITY FOR VALUABLES: I understand and agree that money, jewelry, and other valuables should not be brought into the facility. I understand and agree that Center for Ambulatory Surgery shall not be liable for loss or damage to any personal property.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that have received the Center for Ambulatory Surgery Notice of Privacy Practices.

DISCLOSURE TO FAMILY OR FRIENDS INVOLVED IN MY CARE: I understand that I may limit the disclosure of my health information to family members, other relatives or close personal friends by notifying a member of the staff assigned to care for me.

I have read all the above statements and accept the terms and conditions as stated.

Patient/Parent/Agent/Guardian Signature	Date/Time	Witness Signature	Date/Time
Interpreter (if used) Signature	Date/Time	Witness Signature	Date/Time

TELEPHONE ACCEPTANCE OF TERMS & CONDITIONS

Person contacted: ______________________ Telephone Number: ______________

Relationship to patient: ______________ Date of contact: ________ Time of contact: ________

Person contacted has his/her understanding and acceptance of terms and conditions on behalf of the patient.

Speaker Signature	Date/Time	Witness Signature	Date/Time

PHOTO IDENTIFICATION OBTAINED: ☐ YES ☐ NO

NOTE: If the individual signing is the Health Care Agent or Guardian(s), he/she must provide written documentation to authorize his/her legal authority to consent. A copy of the documentation must be placed in the patient's medical record.