

ADMISSION AGREEMENT

Consent for Admissions: I request and consent to admission to the Windhaven Surgery Center

Consent to Medical Care: I request and consent to medical care and diagnostic procedures that my attending physician(s) or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in the Windhaven Surgery Center is under the direction of my attending physician(s) and the center is not responsible for acts of omission of my attending physician(s).

Unborn Child Coverage: If pregnant, the above consent for treatment, releases, assignments, and guarantor agreement apply to my newborn child if born at this center during this period of treatment.

Release of Information: I authorize the Windhaven Surgery Center to release any medical or financial information to a medical care provider who is performing medical care or a diagnostic test(s) on behalf of, or at the request of my attending physician, or his/her designees, of the Center. I authorize the Center, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. By state law, you must be advised that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Symptoms (AIDS).

Patient Rights: I acknowledge receipt of information explaining my rights as a patient.

Advanced Directive and Organ Tissue Donor: The patient, or his or her representative, hereby acknowledges having been provided with information regarding patient rights and patient’s right to prepare an advance directive. The following documents have been executed.

Advance Directive and/or Living Will	? Yes	? No
Would like more information on Advance Directives	? Yes	? No
Medical Durable Power of Attorney	? Yes	? No
Have you received a Copy of the Bill of Rights	? Yes	? No
Do you have a legal guardian?	? Yes	? No

Please provide Name _____
I have received a copy of the State Notice and this center policy statement regarding Patient Right to Self-Determination.

Personal Property: I have been informed and understand the Center does not assume any responsibility for personal property that I choose to keep with me.

Payment for Medical Care: I agree that in consideration for the medical care I receive from the Center, its employees, agents, designees, or independent contractors. I guarantee full payment for all charges by the Windhaven Surgery Center or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party payor (for example, an insurance carrier or health maintenance organization (HMO) with which Center has specifically entered into an agreement for payment of medical care provided by the Center or by its employees, agents, designees or independent contractors).

ASSIGNMENT OF BENEFITS: I hereby authorize and assign payment to the Center of any type of reimbursement or payment from Medicare or State Medicaid programs or other third party payor, for any and all cost of my medical care provided at the Center or by its agents, designees, or independent medical contractors. Further, I understand that Anesthesiology, Physician Services, Pathology and some Laboratory Services will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim.

Insurance Precertification: I understand that Precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Release of Financial Information: I hereby authorize the Windhaven Surgery Center, its employees, agents, designees, or independent contractor to disclose any and all information regarding the medical care I received on the admission to this Facility or through its employees, agents, and designees, or independent contractors to any third party payor responsible for paying the costs of my medical care and any part thereof.

I have reviewed this Admission Agreement and fully understand its contents and implications. I also acknowledge that I have received a copy of the patient’s right to self determination of treatment.

Signature of Patient, Parent, Legal Guardian, Representative Date/Time Please Print Name of Patient, Parent, Guardian

Signature of Guarantor Relationship to Patient Date/Time Please Print Name of Guarantor

Signature of Witness Date/Time Please Print Name of Witness

If Legal Guardian or Other Legal Representative for the Patient, please provide your age and relationship to the patient, and the reason why the Patient is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or a parent or legal guardian of a child.