CENTRAL JERSEY AMBULATORY SURGERY CENTER (CJASC)

Patient Label

READ ONLY

FACILITY CONSENT FORM

PATIENT'S NAME: ______________________________

PHYSICIAN'S NAME: ______________________________

CONSENT FOR TREATMENT:

I, THE ABOVE-NAMED AND UNDERSIGNED PATIENT, GIVE MY CONSENT FOR CARE AT AND BY THE MEDICAL, NURSING ALLIED PROFESSIONAL STAFF OF THE ABOVE SURGICAL CENTER, WHICH MAY INCLUDE ROUTINE DIAGNOSTIC PROCEDURES AND SUCH MEDICAL TREATMENT AS MY DOCTOR OR HIS/HER DESIGNEES MAY FIND ARE NEEDED. I ACKNOWLEDGE THAT NO PROMISES OR GUARANTEES HAVE BEEN MADE TO ME ABOUT THE RESULTS OF ANY EXAMINATIONS, TREATMENTS OR PROCEDURES I MAY RECEIVE WHILE AT THE CENTER.

RELEASE OF MEDICAL RECORDS:

I AUTHORIZE THE CENTER TO RELEASE ALL OR ANY PART OF MY MEDICAL RECORD TO (A) HOSPITALS OR MEDICAL SERVICE COMPANIES, INSURANCE COMPANIES, WORKERS' COMPENSATION CARRIERS, WELFARE FUNDS OR OTHER ORGANIZATIONS OR AGENCIES THAT MAY BE CONCERNED WITH THE PAYMENT OF COSTS RELATED TO MY TREATMENT AND (B) ANY OTHER ORGANIZATION OR AGENCY TO WHICH THE CENTER IS PERMITTED TO RELEASE SUCH INFORMATION UNDER APPLICABLE LAWS. IN THE EVENT I AM TRANSFERRED OR ADMITTED TO A HOSPITAL POST-OPERATIVELY(or require Emergency Room care within 24 hours post-operatively), I AUTHORIZE THE CENTER TO OBTAIN A COPY OF THE HOSPITAL DISCHARGE SUMMARY.

FINANCIAL ARRANGEMENTS:

I AUTHORIZE AND DIRECT MY INSURER OR PAYOR TO PAY DIRECTLY TO THE ABOVE CENTER ANY OR ALL BENEFITS, UP TO THE AMOUNT OF MY BILL, ACCRUING TO ME IN CONNECTION WITH MY TREATMENT. I AGREE THAT, IN CONSIDERATION OF THE SERVICES THAT WERE PROVIDED TO ME, I INDIVIDUALLY OBLIGATE MYSELF TO PAY THE AMOUNT PROMPTLY IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF THE FACILITY. I UNDERSTAND, THEREFORE, THAT TO THE EXTENT PERMITTED UNDER APPLICABLE LAWS AND CONTRACTUAL ARRANGEMENTS, I AM FINANCIALLY RESPONSIBLE TO THE CENTER FOR ANY AMOUNTS NOT COVERED BY INSURANCE. FURTHERMORE, I UNDERSTAND THAT MY INSURER OR PAYOR MAY REQUIRE CERTAIN HEALTH CARE SERVICES TO BE AUTHORIZED BEFORE THEY ARE FURNISHED TO ME. I INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF THE CENTER WITH RESPECT TO THE SERVICES THAT I CHOOSE TO RECEIVE NOTWITHSTANDING THAT MY HEALTH INSURER OR PAYOR HAS REFUSE TO GIVE PREAUTHORIZATION FOR ALL OR ANY PORTION OF MY SERVICES.

PRE-CERTIFICATION:

YOUR INSURANCE COMPANY WILL BE CALLED TO PRE-CERTIFY YOUR PROCEDURE. PLEASE MAKE SURE THAT WE HAVE THE CORRECT INSURANCE INFORMATION. IT IS IMPORTANT TO NOTIFY US IF YOU HAVE DIFFERENT PLANS FOR PHYSICIAN AND HOSPITAL SERVICES.

☐ I UNDERSTAND I AM USING MY OUT OF NETWORK BENEFITS. THIS FACILITY IS NOT CONTRACTED WITH MY INSURANCE COMPANY TO PROVIDE SERVICES. I UNDERSTAND THAT THE REIMBURSEMENT MAY BE SENT TO ME INSTEAD OF THE CENTER. UPON RECEIPT OF THE INSURANCE PAYMENT, I WILL FORWARD THE CHECK AND THE EXPLANATION OF BENEFITS TO THE CENTER. I UNDERSTAND THAT MY INSURANCE PLAN MAY STILL HOLD ME RESPONSIBLE FOR A DEDUCTIBLE AND/OR COINSURANCE.

FACILITY CHARGE:

WHEN YOUR PROCEDURE IS PERFORMED AT THE ABOVE SURGICAL CENTER, THERE WILL BE A FACILITY FEE. THERE IS A CHARGE FOR THE USE OF THE SURGICAL SUITE FOR YOUR PROCEDURE. FEES WILL VARY ACCORDING TO THE TYPE OF PROCEDURE(S) THAT IS / ARE BEING PERFORMED. PATIENT RESPONSIBILITY IS DEPENDENT UPON INDIVIDUAL INSURANCE PLANS.

IF YOU HAVE ANY QUESTIONS REGARDING THE ABOVE INFORMATION, PLEASE SPEAK WITH THE ADMINISTRATOR.

COLLECTION EXPENSES: (MEDICARE/MEDICAID EXCLUDED)

SHOULD MY ACCOUNT WITH THE SURGERY CENTER BE REFERRED TO AN ATTORNEY OR OUTSIDE AGENCY FOR COLLECTION, I WILL PAY ALL REASONABLE COLLECTION EXPENSES (INCLUDING ATTORNEY'S FEES) ASSOCIATED WITH THE COLLECTION EFFORT. I ACKNOWLEDGE THAT ALL DELINQUENT ACCOUNTS WILL BEAR INTEREST AT THE LEGAL RATE.

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additional charges

PROFESSIONAL FEES:

THESE ARE THE FEES THAT ARE BILLED BY YOUR PHYSICIAN FOR HIS SERVICES IN PERFORMING YOUR PROCEDURE. THESE FEES ARE WITHIN THE RANGE CONSIDERED USUAL AND CUSTOMARY FOR THIS AREA. PATIENT RESPONSIBILITY WILL VARY ACCORDING TO EACH INSURANCE PLAN.

FOR QUESTIONS PERTAINING TO YOUR PHYSICIAN'S BILL: PLEASE CONTACT YOUR SURGEON

ANESTHESIA:

A CERTIFIED ANESTHESIOLOGIST WILL BE PARTICIPATING IN YOUR PROCEDURE IN ORDER TO PROVIDE COMFORT AND SAFETY. THIS SERVICE WILL BE BILLED TO YOUR INSURANCE COMPANY.

BIOPSIES:

IF A BIOPSY IS REQUIRED DURING THE COURSE OF YOUR PROCEDURE, A TISSUE SAMPLE WILL BE SENT TO A LABORATORY TO BE ANALYZED BY A PATHOLOGIST. YOU MAY RECEIVE A SEPARATE BILL FROM THE PATHOLOGIST.

HIPAA:

- I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE HIPAA PRIVACY REGULATIONS.

PATIENT RIGHTS/ADVANCE DIRECTIVE/DISCLOSURE OF OWNERSHIP:

I HAVE BEEN OFFERED WRITTEN AND GIVEN VERBAL NOTIFICATION OF THE FOLLOWING:

- PATIENT RIGHTS & RESPONSIBILITIES.
- THE FACILITY POLICY ON ADVANCE DIRECTIVES
- DISCLOSURE OF OWNERSHIP (IF APPLICABLE)

ADVANCE DIRECTIVE/LIVING WILL:

- I HAVE AN ADVANCE DIRECTIVE OR LIVING WILL: ☐ YES ☐ NO
- I HAVE BROUGHT MY ADVANCE DIRECTIVE OR LIVING WILL WITH ME: ☐ YES (copy made) ☐ NO (forgot it)
- INFORMATION ON ADVANCE DIRECTIVES WAS OFFERED TO ME BY THE ASC ☐ YES ☐ NO

"It is the policy of the center, regardless of the contents of an Advance Directive or instructions from a Health Care surrogate or Power of Attorney that if an adverse event occurs during treatment, the center personnel will initiate resuscitative or other stabilizing measurers, and transfer the patient to an acute care hospital for further evaluation".

CLOTHING AND VALUABLES:

I FULLY UNDERSTAND THAT **CJASC** IS **NOT** RESPONSIBLE FOR ANY PERSONAL PROPERTY (CLOTHING, EYEGLASSES, DENTURES, ETC.) BROUGHT IN OR RETAINED IN THE LOCKERS AT ANY TIME. I FULLY UNDERSTAND THAT ANY VALUABLES (MONEY, JEWELRY, AND KEYS) SHOULD BE GIVEN TO A FAMILY MEMBER OR OTHER RESPONSIBLE PARTY FOR SAFE KEEPING.

ACKNOWLEDGEMENT OF DRIVING RISKS:

I HAVE BEEN INFORMED BY **CJASC** THAT I SHOULD NOT DRIVE FOR AT LEAST 24 HOURS AFTER COMPLETION OF MY PROCEDURE. A RESPONSIBLE ADULT, UPON DISCHARGE FROM **CJASC**, WILL ACCOMPANY ALL PATIENTS WHO HAVE RECEIVED GENERAL / INTRAVENOUS SEDATION / SPINAL / EPIDURAL ANESTHESIA. ALL PATIENTS WHO HAVE HAD LOCAL ANESTHESIA WITHOUT SEDATION, AND WHO MEET THE DISCHARGE CRITERIA MAY BE DISCHARGED UNESCORTED.

PATIENT SIGNATURE

THE UNDERSIGNED CERTIFIES THAT THIS FORM HAS BEEN FULLY EXPLAINED TO HIM/HER, AND THE UNDERSIGNED IS SATISFIED THAT HE/SHE UNDERSTANDS ITS CONTENTS AND SIGNIFICANCE.

SIGNATURE OF PATIENT _______________ DATE _______________

PATIENT IS A MINOR OR UNABLE TO SIGN BECAUSE:

THE UNDERSIGNED CERTIFIES THAT THIS FORM HAS BEEN FULLY EXPLAINED, AND THE UNDERSIGNED IS SATISFIED THAT THE CONTENTS ARE UNDERSTOOD. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS BEEN DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S LEGAL REPRESENTATIVE OR GUARDIAN TO EXECUTE THE ABOVE AND ACCEPT ON BEHALF OF THE PATIENT.

SIGNATURE OF REPRESENTATIVE / LEGAL GUARDIAN _______________ DATE _______________

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