# LEWES SURGERY CENTER
# IMPORTANT NOTICES

## FINANCIAL AGREEMENT

I hereby authorize Lewes Surgery Center to access and use my insurance information to submit claims to my insurance carrier on my behalf for services rendered. The Facility is not obligated to file insurance claims unless a contractual agreement is in place with this Facility your Insurance Company. Out of network claims will be filed as a courtesy; I acknowledge I will be responsible for unpaid portions of out of network claims. Self-pay, non-insured, and cosmetic patients will be expected to remit payment prior to or no later than checking in for the scheduled date of service. Patient's who have an assignment of benefits including insurance deductible, coinsurance, or copay will be expected to make payment at the time services are rendered. Payment arrangements may be made in accordance with our payment plan policy; financial arrangements are to be discussed and approved by the Facility Billing Department prior to visits.

Lewes Surgery Center accepts cash, checks, and all major credit cards. Checks returned for non-sufficient funds will be charged a $40 returned check fee; I acknowledge and understand this fee will be applied to my account balance.

Patients who neglect to make payment on account balances due or do not honor minimum payment plan criteria will result in account turnover to a collection agency and incur a fee of 28% of balance due for administrative and collection service fees. This amount will be applied to your outstanding account balance. I hereby acknowledge that I am responsible for balances due on my account and understand I will incur additional fees for unpaid balance(s) resulting in collection turnover.

## ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby requests that Lewes Surgery Center file a claim to my insurance carrier; I hereby assign benefits to be paid on my behalf of Lewes Surgery Center for all services rendered. The undersigned guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments. Charges not paid by the provided insurance or third party within a reasonable period of time may be assigned to the undersigned for payment. Charges for insurance non-covered services will be the responsibility of the undersigned and billed to the undersigned for payment. Medicare or Medicaid limitations may apply to non-covered service charges. I hereby certify that the information given regarding my insurance coverage is accurate and correct.

## RELEASE OF MEDICAL RECORDS

I authorize Lewes Surgery 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 regulations, where required by my insurance carrier for insurance claim payment of services or to any physician responsible for continuation of my care.

## PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have received, both verbally and in written format, Lewes Surgery Center's - Patient's Rights information. Furthermore, I have had the opportunity to read the notice, ask questions regarding my rights as a patient and understand all information as presented.

## FINANCIAL INTEREST DISCLOSURE

I am aware that Lewes Surgery Center is a physician owned facility. The physicians listed below have a financial and ownership interest in Lewes Surgery Center. I acknowledge that I have selected to have my procedure performed at the Center after considering both my physician's financial interest in Lewes Surgery Center and that I understand I retain the choice to have the procedure performed at a different facility.

Edward Jaoude, MD; Roman Orsini, DPM; Edmund Carroll, DO; Mohammad Mehdi, MD; Gita Pillai, MD; Claire Capobianco, DPM; Scott Schulze, MD; Karen Rudo, MD; Joseph M. Farrell, DO; Justin L. Elder, DO.

## ADVANCE DIRECTIVES

Lewes Surgery Center acknowledges that all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Lewes Surgery Center respects and upholds those rights.

However, unlike in an acute care hospital setting, Lewes Surgery Center does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this facility are considered to be of minimal risk and of an elective nature. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, Lewes Surgery Center staff can direct you to the appropriate state agency to do so. If you have an Advance Directive, you can provide a copy to the facility and in the unlikely event that an emergency arises, and transfer to a hospital for further care is needed, your Advance Directives will be sent with your chart to the receiving hospital.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

## HIPAA NOTICES OF PRIVACY PRACTICES

I acknowledge that I have received, both verbally and in written format, Lewes Surgery Center's HIPAA Notices of Privacy Practices information. Furthermore, I have had the opportunity to read the notice, ask questions regarding my rights as a patient and understand all information as presented

## CALL, TEXT, AND EMAIL NOTIFICATION AUTHORIZATION

Lewes Surgery Center communicates with patients for a variety of reasons including financial calls, pre and post operative calls, scheduling calls and other. I hereby authorize Lewes Surgery Center to:

Leave a message on my answering machine with private medical or financial information: Yes ___ No ___

Notify me by text or email communication regarding appointments, pre-operative information or requests, post procedure follow-up, and/or financial communication: Yes___ No___

Discuss my medical or financial information referenced with someone else: Yes _____ No _____ Name of person(s) which discussion is approved: _____

By signing below, I hereby acknowledge that I have received and understand in full the aforementioned notices provided by Lewes Surgery Center. I accept all terms and conditions as outlined in this notice.

Signature_____Date_____

**Patient or Surrogate Signature**

Printed Patient or Surrogate Name _____

If Surrogate, Relationship _____Time_____

Complete only if receiving notice on the same day as the referral for the procedure.