New Jersey Surgery Center, L.L.C.

Consent for Admission and Treatment	*Place Patient Sticker Here*

Consent to Medical Care: I request admission to New Jersey Surgery Center and authorize the facility, staff and physicians to provide 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 New Jersey Surgery Center is under the direction of my attending physician(s) and that New Jersey Surgery Center is not responsible for acts of omission of my attending physician(s). I authorize New Jersey Surgery Center to retain or dispose of any specimen or tissue taken from the above named patient.

Teaching Programs: I understand that this New Jersey Surgery Center is a facility that promotes education opportunities, and therefore, I understand that I may be seen and examined by supervised participants as a part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at any time.

Disclosure of Information: The undersigned agrees that all records concerning this patient's hospitalization shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that **THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWS AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

Special Consent for HIV Testing: The undersigned specifically consents to the testing of the patient's blood or human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, its expected benefit, and has been given the opportunity to ask questions about the blood test.

☐ Do ☐ Do Not I (we) authorize New Jersey Surgery Center and/or my physician and/or physician to photograph/video or permit other persons to photograph/video for such purposes as may be deemed necessary.

☐ Do ☐ Do Not I (we) consent to the presence of students, residents or fellows, and vendors in the operating room to observe the procedure. I am aware that only the physician may grant this permission on my consent.

☐ **Patient's Initials: _____ Advance Directives:**

I (we) acknowledge the following statement in regards to Advanced Directives: New Jersey Surgical Center suspends Advanced Directives for elective surgery and procedures in part because anesthetic drugs often require supportive measures including intubation and/or blood pressure support.

If you have any questions please talk to your physician or anesthesiologist.

Patient Rights: I acknowledge receipt of information explaining my rights as a patient and, on request, I received a copy of the State notice and this facility policy statement regarding Patient's Right to Self-Determination.

I have been informed that my physician may be a partner in ownership of New Jersey Surgery Center. I have the right to review a list of partners. The Physicians and Allied Health Professionals (AHPs) practicing at New Jersey Surgery Center are licensed and/or credentialed to practice in this facility. The physicians and AHPs provide medical services at New Jersey Surgery Center, but they are not agents or employees of New Jersey Surgery Center.

Financial Agreements: For services hereto performed or to be performed for the Patient by New Jersey Surgery Center (whether one or more), below signed (severally if more than one), whether as patient, agent or guarantor, agrees and promises to pay the charges for the care so provided to the Patient by New Jersey Surgery Center in accordance with New Jersey Surgery Center's then current standard rates and all costs incurred in collecting same, together with attorney's fees, which New Jersey Surgery Center deems necessary and reasonably required to enforce the rights of New Jersey Surgery Center.

Assignment of Insurance Benefits to New Jersey Surgery Center. As or on behalf of the Insured under the insurance specified on the registration documents of the Patient, and otherwise payable thereto (the present and future rights thereto and monies due or to become due therefrom termed "Contract Rights"), the below signed irrevocably assigns and transfers to New Jersey Surgery Center the Contract Rights, **and orders and directs such insurer(s) to pay all monies due or to become due thereunder directly to New Jersey Surgery Center or its assignee**. To effect such payment, New Jersey Surgery Center is irrevocably constituted and appointed lawful attorney in fact with substitution power, to sue or otherwise collect and settle any claim under the Contract Rights as insured without further notice or approval of Insured and to endorse in the name of the Insured any check or other instrument for the payment of monies thereunder. Further, I understand that **ANESTHESIOLOGY, PHYSICIAN SERVICES, PATHOLOGY, RADIOLOGY** 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.

If Insured receives monies directly from the Insurer(s), **same shall be held in trust and immediately transferred to New Jersey Surgery Center for amounts due**. This assignment is irrevocable with interest until full and complete payment of all monies due to the Facility and its affiliates from this event of admission or otherwise. Money received by New Jersey Surgery Center from Insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered to the Patient. If charges not covered by insurance cannot be paid in full when due, below signed agrees upon request to sign a promissory note bearing interest at the maximum legal rate to pay all debt not paid, if credit is approved.

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

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.

Medicare Assignment, Patient's Certification, Authorization to Release Information and Payment Request:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Acknowledgement of Notice of Privacy Practices: A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admissions packet and posted in the Facility. By signing below you acknowledge that you have received a copy of the Facility's Notice of Privacy Practice.

I GIVE PERMISSION for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. ☐ **Yes** ☐ **No**

☐ **Limited disclosure to persons listed below:**

Name: _____

Name: _____

Name: _____

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS "CONDITIONS OF ADMISSION AND TREATMENT" FORM.

PATIENT
SIGNATURE: ✕ _____ Date: _____

WITNESS: ✕ _____ Date: _____

Patient (is a minor _____ years of age) OR is unable to consent because: _____

Relative / Authorized Agent _____

Relationship to Patient: _____ Date: _____