Disclosure Notice
Westover Hills Surgery Center

RELEASE OF INFORMATION: I agree that the Facility may disclose my protected health information (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer. This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my **personal** health information will not be disclosed unless I agree to disclosure.

FINANCIAL AGREEMENT: I agree to pay the Center in accordance with its regular rates and terms.
TERMS: Net 30 days from date of invoice unless otherwise indicated above. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs and filing fees.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize direct payment to the Center of any insurance benefit. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

DISCLOSURE OF OWNERSHIP: The physician who refers you to our Surgery Center may have an ownership interest in this facility. You are free to choose another facility in which to receive services. _____ (Please initial)

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with Federal law, the Center is notifying you that it will NOT HONOR previously signed advance directives. If this is not acceptable to you, you must address this issue with your physician and anesthesiologist/anesthetist. _____ (Please initial)
Please check one of the following:

- ○ YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record
- ○ YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me
- ○ NO, I do not have an Advanced Directive/Living Will/Health Care Proxy

HIPAA PRIVACY NOTICE: I acknowledge that I have received the Facility's HIPAA Privacy Notice and have had the opportunity to review its content. _____ (Please initial)

RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received a copy of the Patient Rights and Responsibilities.

_____
(Please initial)

ITEMIZED BILL: I understand that I am entitled to an itemized bill upon my request _____ (Please initial).
Itemized statement will be mailed in two or three weeks.

I certify that I have read this document, and am the patient, or am duly authorized to execute it and accept its terms.

_____
Patient Signature Date

_____
Patient/Parent/Guardian/ or Conservator Date

_____
If signed by anyone other than the patient – please indicate relationship