ADMISSION AGREEMENT

Consent for Admissions: I request and consent to admission to High Plains Surgery Center (*HPSC*).

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 *HPSC* is under the direction of my attending physicians(s) and that the Center is not responsible for acts of omission of my attending physician(s).

Release of Information: I authorize *HPSC* 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 *HPSC*, 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 includes, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Legal Guardian, Medical Durable Power of Attorney, Advance Directives:

Do you have a Legal Guardian? ☐ Yes ☐ No
If yes, please provide Name_____
Do you have a Medical Durable Power of Attorney? ☐ Yes ☐ No ☐ Copy on Chart
If yes, please provide Name_____
Do you have an Advance Directives? ☐ Yes ☐ No ☐ Copy on Chart

Privacy Practices, Patient Rights, Physician Ownership, Advance Directives and Patient Financial Responsibility Policies:

Have you received a copy of the HPSC Notice of Privacy Practices? ☐ Yes ☐ No
Have you received a copy of the HPSC Patient Rights and Responsibilities? ☐ Yes ☐ No
Have you received a copy of the HPSC Physician Ownership Statement? ☐ Yes ☐ No
Have you received a copy of the HPSC Advance Directives Policy? ☐ Yes ☐ No
Have you received a copy of the HPSC Patient Financial Responsibility Policy? ☐ Yes ☐ No

Personal Property: I have been informed and understand *HPSC* does not assume any responsibility for personal property that I choose to keep with me. I have been informed; however, that *HPSC* does have a safe in which I can deposit personal property for safekeeping. I have been informed and understand that *HPSC* will not be liable for any loss of my personal property unless it is placed in the safe maintained by *HPSC*.

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 changes by *HPSC* 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). In the event that *HPSC* has to engage an attorney or collection agency to collect any unpaid balances that arise form the treatment consented to and services provided herein, I agree to pay the reasonable attorney's fees and collection expenses, including, without limitation, collection agency expenses, incurred by *HPSC.*

Assignment of Benefits: I hereby authorize and assign payment to *HPSC*, 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, Radiology** and some **Laboratory Services** may be billed to me separately and I 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 herby authorize *HPSC*, 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.

Signature of Patient, Parent, or Legal Guardian		Date	Please Print Name of Patient, Parent, Guardian
Signature of Guarantor	Relationship to Patient	Date	Please Print Name of Guarantor
HPSC Employee Signature		Date	Please Print Name of HPSC Employee

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 are a parent or legal guardian of a child.

World Class Physicians. Hometown Care
HIGH PLAINS
SURGERY CENTER

Place Patient Sticker Here