Multiple Authorization Form

2880 Atlantic Avenue, Suite 160 Long Beach, CA 90806-1715 Phone: (562) 988-9566 Fax: (562) 988-7863

Surgery Center of Long Beach

Multiple Authorization Form

Financial Agreement

In the event that my insurance will pay all or part of the Center's charges, the Center which rendered service to me are authorized to submit a claim for payment to my insurance carrier. The Center is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co- insurances at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. Please note, the surgery center's facility fee includes charges for operating room and recovery room services, which are provided by the center. This does not include fees for surgeon, anesthesiologist, pathologist or radiologist, implants and/or laboratory fees for which you will be billed separately, if applicable. Please contact Surgery Center of Long Beach in advance if you have any questions.

Assignment of Insurance Benefits

I hereby assign benefits to be paid on my behalf to Surgery Center of Long Beach, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who rendered service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regards to insurance coverage is correct.

Release of Medical Records

I authorize the 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, when required for submission of any insurance claim for payment or to any physician(s) responsible for continuing care.

Disclosure of Ownership

I have been informed prior my procedure that the physicians who perform procedures/services at Surgery Center of Long Beach may have ownership interest in Surgery Center of Long Beach. The physician has given me option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Surgery Center of Long Beach.

HIPAA/Privacy Notice Acknowledgement

I hereby acknowledge that a copy of the notice of the HIPAA/Notice of Privacy Practices for Surgery Center of Long Beach has been made available for me. I have the right to obtain a paper copy upon request.

Certification of Patient Information

I have reviewed my patient demographic and insurance information on this date and verify that ALL information reported to the Center is correct.

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Patient Rights/Advance Directives Information

I have received written and verbal notification regarding my Patient Rights prior to the procedure. I have also received information regarding Surgery Center of Long Beach policies and pertaining to ADVANCE DIRECTIVES prior to the procedure. ADVANCE DIRECTIVES will not be honored within the Center, however, if an adverse event occurs during treatment, patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. Advance Health Care Directive forms are available and will be offered to all patients.

Patient Consent to Contact

By providing your contact information provided on your demographics page and completing this form, you agree to the following:

I hereby consent and authorize Surgery Center of Long Beach, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information. To revoke your consent to receive text messages or electronic mail from Surgery Center of Long Beach, you may unsubscribe by replying and entering “Unsubscribe.” If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone,

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

Signatures

Patient signature

_____

Date signed

_____

Parent or guardian signature (if patient is a minor)

_____

Date signed

_____