Treasure Coast
Surgical Center, Inc.
1811 S. 25th Street • Fort Pierce, FL 34947
(772) 467-1960

PATIENT CONSENT - BUSINESS AND ADMINISTRATION

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesia provider, radiologist, or pathologist are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, to medical or surgical treatment or procedures. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's physician and not to the surgery center employees.

OTHER PROFESSIONAL SERVICES: I understand that my physician may have a professional radiology service review radiological images. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physicians and laboratories.

PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property brought by patient to the surgery center, including but not limited to money, jewelry, documents, or any other articles.
I also agree and understand that the surgery center shall not be held responsible for any loss or damage to dentures as well as partial appliances, damage or breakage to tooth (teeth), crowns, caps, or the like.

OWNERSHIP OF SURGERY CENTER: I have been informed there are physicians who have ownership in this surgery center.
I understand that I am free to choose another facility in which to receive services.

ADVANCE DIRECTIVE/LIVING WILL: I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will still transfer me to a hospital which will make decisions about following any advance directive or living will.

I have the following:	**Copy given to Surgery Center**
☐ **Living will**	☐
☐ **Health care surrogate, proxy, or durable power of attorney**	☐
☐ **Power of Attorney**	☐
☐ **Guardianship**	☐
☐ **NONE of the Above**	☐

PATIENT PRIVACY, RIGHTS AND RESPONSIBILITIES: I have been provided a copy of the Privacy Notice. I received a copy of the patient rights and responsibilities statement. I know to whom I can express suggestions or complaints. ***If I should be transferred to a hospital or if I am seen at a hospotal within a week of my procedure, I grant consent for the hospital to release copies of my medical records to the surgery center to review the episode of care.***

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers). Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms should my insurance company deny payment. I understand the fees quoted are only an estimate. If any additional procedure(s) are added or special supplies/implants are used I will be billed accordingly. I shall also be responsible for any deductibles or co-payments owed at the time of services. I am responsible for payment within 60 days of the date of the service provided unless there is a contract the surgery center has signed with my insurer that states otherwise. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law. I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any other payer is correct. I assign to the Surgery Center all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services.

I authorize payment of medical benefits to the surgery center for the services provided.

I hereby acknowledge the above statements.

I also acknowlwdge I have received the following items prior to the date of the procedure.
- ☐ **Patient Rights and Responsibilities**
- ☐ **The surgery center's policy about advance directives**
- ☐ **Physician ownership information**

(In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physical or mental condition, complete the following.) If patient's personal representative, state relationship and authority:

Patient's Representative Date Time

Witness Date Time

PATIENT LABEL