Lakes Surgery Center
Consent and Conditions of Treatment

Thank you for choosing Lakes Surgery Center to provide for your health care needs. We are committed to providing exceptional healthcare. The first step in this process is to provide information regarding patient rights, risks and responsibilities. The second step is to obtain consent to treat the patient. The admitting staff can answer any questions you may have in regards to the following agreement.

I agree to the following:

1. **CONSENT TO TREAT:** I (we) consent to the treatment or admission to Lakes Surgery Center for services or supplies that have been or may be ordered by a licensed professional health care provider. I (we) understand that treatment may include but is not limited to; radiological examinations, laboratory procedures, physical therapy, anesthesia, nursing care or medical and surgical treatment. I (we) understand that some procedures may include videotaping or other imaging. I (we) understand that all licensed professional health care providers that render service to the patient are responsible and liable for their own acts, orders and omissions. I (we) acknowledge that the center has not made nor can it make a guarantee of the outcome of treatment.

2. **FINANCIAL AGREEMENT:** I (we) agree to pay for all services and supplies rendered to the patient in accordance with the rates and financial policies in effect at the time of service. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I (we) authorize any overpayment made on this account to be transferred to any other account balance for which I am responsible. I (we) agree to pay standard interest fees on any unpaid balance after 120 days of discharge or date of service. If this account is assigned to an attorney or a collection agency for collection then I (we) agree to pay all collection agency fees, court costs, and attorney's fees. Failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

3. **ASSIGNMENT OF INSURANCE BENEFITS:** I (we) assign and authorize payment directly to Lakes Surgery Center of any healthcare benefits that the patient is entitled to receive. This assignment will not be withdrawn or voided at any time unless I pay the account in full. I (we) understand that I am responsible for any and all charges not covered by my insurance policy(s). If the patient is entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of benefits directly to Lakes Surgery Center.

4. **ASSIGNMENT OF PHYSICIAN BENEFITS:** I am (we) are aware that physician services provided by Surgeon, Radiologist, Pathologist, Anesthesiologist, as well as medical, surgical and emergency care are not billed by the center but are billed separately. I (we) understand that I am under the same obligation to those providers as stated in this agreement unless otherwise agreed to in writing with those providers. I (we) authorize payment of any medical benefits for such claims to the appropriate provider.

5. **RELEASE OF PROTECTED HEALTH INFORMATION:** A copy of the HIPAA Privacy Notice as prepared by Lakes Surgery Center has been made available to the patient and I authorize the center or any professional healthcare provider who rendered services to the patient to release protected health information in accordance with HIPAA privacy regulations.

6. **PERSONAL VALUABLES AND BELONGINGS:** I (we) agree that the center is not responsible for the loss or damage of any article, valuables or personal property.

7. **ADVANCE DIRECTIVE/LIVING WILL:** Federal Law requires that the center provide all adult patients with information about their right to make an Advanced Directive or Living Will. **PLEASE MARK ONE OF THE FOLLOWING:**
   [ ] The patient has a Living Will or Durable Power of Attorney and provided a copy to the center at the time of registration.
   [ ] The patient has a Living Will or Durable Power of Attorney and requests that a copy be placed in their medical record.
   Copy available from:____
   [ ] The patient requests information in regards to their right to make advance healthcare directives.
   [ ] The patient declines information in regards to their right to make advance healthcare directives.
   [ ] The patient does not have an Advanced Directive.
   Action taken :____ Date:_____________________

Because the use of anesthetic drugs may produce significant changes in my vital systems. I understand that "Do Not Resuscitate" or similar orders will be discussed with my surgeon and anesthesiologist prior to my operation or procedure to insure that my wishes will be accommodated .

I understand and accept the terms of this agreement as well as the Patient Rights and Responsibilities listed on the back of this form and certify that I am the patient or I am duly authorized by the patient or by law to execute the above agreement in their behalf.

_______________________________________ Date ____/____/____ Time_________
Patient Signature

______________________________ _______________ ____
Patient's Guardian or Representative Relationship Witness Date/Time