Patient Information

Last Name	First Name	MI	Date

Address	City	State	Zip

Phone (H)	Phone (C)	DOB	Gender	Email

Responsible Party	Relationship	Phone

Primary Insurance Name	Insurance Policy Holder	DOB	Relationship

ID#	Group#	Employer

Secondary Insurance Name	Insurance Policy Holder	DOB	Relationship

ID#	Group#	Employer

Emergency Contact	Emergency Phone	Relationship

Pharmacy Information

Pharmacy Name	Phone	Pharmacy Cross Streets/Address

Consent for Medical Care

I request admission to COMPREHENSIVE SURGICAL CARE (CSC) and authorize the facility, staff and physicians to provide 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 CSC is under the direction of my attending physician(s) and that CSC is not responsible for acts of omission of my attending physician(s). I authorize CSC to retain or dispose of any specimen or tissue taken from me.

Acknowledgement - Receipt of Patient Rights & Responsibilities and Notice of Privacy Practices

I acknowledge receipt of the Patient Rights & Responsibilities and have been given the opportunity to review it. I understand this information is available to me upon request at any time. A description of how my medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in the admissions packet and/or is posted in the Facility. By signing below, I acknowledge I have had the opportunity to review a copy of the Facility's Notice of Privacy Practice and Patient Rights & Responsibilities.

Disclosure of Information

The undersigned agrees all records concerning this patient's care shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the Facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, worker's compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the Facility advise the undersigned that THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWS AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

Disclosure of Information to Family and Others

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. Yes ☐ No ☐ Limited disclosure to person listed below: ☐

Name	Phone Number

Transportation Release

I understand that the anesthetic to be administered to me may have effects that make it hazardous for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. I understand that CSC will not perform my scheduled procedure unless these arrangements are met and have provided CSC with my designated responsible party's name and phone number. The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.

Responsible Adult Driver Name (if different than above)	Phone Number

Special Consent for HIV Testing

The undersigned specifically consents to testing the patient's blood for human immunodeficiency virus (AIDS) and/or Hepatitis if attending physician determines it necessary (i) to determine appropriate treatment/procedures for patient or (ii) for protection of attending physician and/or any employee/agent of the Facility if exposed to patient's bodily fluids which could transmit such disease, and has been informed of the nature of the blood test, its expected benefit, and given the opportunity to ask questions.

Blood Products & Surgical Instruments

I acknowledge CSC does not provide blood bank services, and does not administer blood or blood products including but not limited to plasma, platelets, or albumin. And that CSC may utilize surgical instruments that have been reprocessed through a stringent cleaning and sterilization process.

Advanced Directives

I (we) acknowledge the following statement in regard to Advanced Directives: CSC suspends Advanced Directives for elective surgery and procedures in part because sedation and anesthetic drugs often require supportive measures including intubation and/or blood pressure support. In the event of a life-threatening event, emergency medical procedures will be implemented. 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. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs), paramedics, or hospital personnel not to resuscitate you. Sometimes this is called a DNR- Do Not Resuscitate. If you have this form, EMTs, Paramedics, and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions necessary to provide comfort care or to alleviate pain. IMPORTANT: Under New Mexico law Medical Orders for Scope of Treatment form (MOST) must be on letter sized paper of a Wausau Astrobright Terra Green 65lb. cardstock to be valid. If you have any questions, please talk to your physician or anesthesiologist. Visit https://www.caringinfo.org/ for more info.

I have an Advanced Directive ☐ I do not have an Advanced Directive ☐ A copy has been given to Facility(CSC) ☐

Ownership

I acknowledge my physician may be a partner in ownership of CSC and have the right to review a partner list (posted in view). Physicians/Allied Health Professionals practicing here are licensed and/or credentialed to practice at CSC and provide services here but are not agents/employees of CSC.

Pre-operative Instructions

I acknowledge my physician and/or CSC have notified me of pre-operative instructions for my procedure , and that I have followed those instructions. I have been instructed not to bring any valuables to the Center. CSC is not responsible for any lost valuables.

Payment Policy

If CSC is not contracted with my insurance or I don't provide insurance information, payment in full is due at time of service. CSC can bill my plan upon receipt of insurance details and refund as needed after the claim has been paid in full. All co-payments, deductibles and co-insurance must be paid at the time of service per my insurance contract. I assume and agree to pay all applicable deductibles and co-pays. Some services may not be covered or not considered medically necessary by Medicare or other insurances. In this case, I will be required to pay for these services in full at time of service. I agree to pay for all non-covered services not paid by my insurance. If pregnant, the above consent for treatment, releases, assignments, and guarantor agreement apply to my newborn child if born at this facility during this period of treatment. As or on behalf of the Insured, under the insurance information provided at registration, and otherwise payable thereto (the present and future rights thereto and monies due or to become due termed "Contract Rights"), I irrevocably assign and transfer to CSC the Contract Rights, and order and direct such insurer(s) to pay all monies due or to become due thereunder directly to CSC or its assignee. To affect such payment, CSC is irrevocably constituted and appointed lawful attorney in fact with substitution power, to sue or otherwise collect and settle any claim under the Contract Rights as insured without further notice or approval of Insured and to endorse in the name of the Insured any check or other instrument for the payment thereunder. Further, I understand PHYSICIANS, ANESTHESIOLOGY, PATHOLOGY, RADIOLOGY and some LABORATORY SERVICES will bill me separately and assign my insurance benefits to them for services rendered during my treatment. I also authorize them to release my medical information to process the claim. If the Insured receives monies directly from the Insurer(s), same shall be held in trust and immediately transferred to CSC for amounts due. This assignment is irrevocable with interest until full and complete payment of all monies due to the Facility and its affiliates from this event of admission or otherwise. Money received by CSC from Insurer(s) or other third-party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered to the Patient. If charges not covered by insurance cannot be paid in full when due, below signed agrees upon request to sign a promissory note bearing interest at the maximum legal rate to pay all debt not paid if credit is approved. Medicare Assignment, Patient's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. For services to be performed by CSC the undersigned, whether as Patient, agent or guarantor, agrees and promises to pay the charges for care so provided to the Patient, in accordance with the Facility's then current standard rates. Patient and Guarantor agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice. Once an account is placed in collection status, all future services must be paid in full at time of service. I understand that there will be a $25.00 fee for any returned checks. I hereby assign all insurance benefits to CSC for services performed.

I/WE THE UNDERSIGNED CERTIFY I/WE HAVE READ AND FULLY UNDERSTAND THIS FORM AND POLICIES IN ITS ENTIRETY.

Signature of Patient/Authorized Agent : _____ Date: _____

Witness Signature : _____ Date: _____

Authorization to Communicate Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

Last Name: First Name: DOB:

In the event that I am unavailable, I hereby authorize CSC to communicate my protected health information, including information regarding my billing, condition, treatment and diagnosis to the following individual(s) or entity:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

If your records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, mental health information, drug/alcohol abuse or sexually transmitted diseases, you are hereby authorizing the disclosure of this information.

Text Message Communication – Duty to Warn: By providing my e-mail or telephone number, I agree that Comprehensive Surgical Care (CSC) may contact me by e-mail or text. I understand that an e-mail or text may not be secure and that there is some risk that it may be read by third parties.

To the extent consent is required the Telephone Consumer Protection Act (TCPA), I hereby authorize delivery of messages containing non-health care communications like appointment reminders, patient satisfaction surveys, account calls, etc. through the use of an automatic/artificial telephone dialing system, pre-recorded voice messages, or e-mail. I am not required to agree to receive such communications and my agreement is not a condition of receiving items or services. Notwithstanding the foregoing, CSC does not waive and expressly reserves the right to contact me by any means for any purposes as otherwise permitted by law. By signing below, I have consented to receive e-mails or non-healthcare pre-recorded communications to the e-mail address or telephone number I have provided.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 1 year from date of signature.

Patient or Authorized Representative Signature: _____ Date: _____