Novamed Surgery Center of Cleveland

DOS: **ID / Visit: /**

PATIENT INFO:

SEX: **DOB:** **AGE:** **HOME PHONE:**

ADDRESS:

SSN: **DRIVERS LICENSE:** **OCCUPATION:** **PH:**

RESPONSIBLE PARTY:

RSP SSN: **RSP OCC:** **RDOB:** **RSP PH:**

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
POLICY: **GROUP:**	**POLICY:** **GROUP:**
AUTH:	**AUTH:**
SUB EMP/PH:	**SUB EMP/PH:**

PERFORMING PHYS: **REFERRING PHYS:**

DIAGNOSIS:

PROCEDURE(S):

RELEASE OF INFORMATION:

The Novamed Surgery Center of Cleveland ("Center") is authorized to furnish information from the patient's medical record to any insurer, compensation carrier, or welfare agency which may be providing financial assistance for Center care. The patient indemnifies the Center and holds it harmless from any and all damage or prejudice which might result to the patient or his/her relatives or heirs from use or misuse by the insurance company of the information turned over to it by the Center pursuant to the patient's written authorization.

STATEMENT TO PERMIT PAYMENT OF OUTPATIENT SURGICAL AND MEDICAL INSURANCE BENEFITS TONOVAMED SURGERY CENTER OF CLEVELAND:

I certify the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

ASSIGNMENT OF INSURANCE BENEFITS:

In consideration for the services rendered to the above named patient, the undersigned hereby authorizes direct payment of any insurance benefits to the Center otherwise payable to me for the admission. I transfer and assign all the right title and interest in the above named insurance company and payment due me to the Center (A photocopy of this form is valid). I hereby authorize the Center, its agents, affiliates and employees to have access to my medical records for the purpose of performing its billing and collection, administrative, financial, and business functions. I further authorize Medicare to furnish medical or other information on this admission required by its intermediary under the Title XVII Program to the extent necessary to process any complementary coverage claim under my agreement in effect with any third party issuer. I assign the benefits payable for facility services to the facility or organization furnishing the services or authorize such facility or organization to submit a claim to Medicare for payment to me.

FINANCIAL RESPONSIBILITY:

In consideration for the services rendered to the above named patient, the undersigned hereby individually obligates him/her to the account of the Center in accordance with the surgery center regular rates and terms regardless of whether insurance payments are available or made on my behalf. In the event it should be necessary to refer the account to any attorney or collection agency for collection; I hereby agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts at the Center bear interest at the legal rate. I understand and agree that I am responsible for providing any information required by my insurance and agree to follow those pre-admission and pre-authorization guidelines which the insurance company may require. I understand that I am financially responsible for all charges which are not covered by insurance, including but not limited to, co-pays, deductibles, charges in excess of policy coverage, and limitations or exclusions of coverage. I certify that I have read the foregoing and that I am the patient, parent, legal guardian or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

I understand the fees quoted are only an estimate. If any additional procedures(s) are added or special supplies/implants are used they will be billed accordingly. I shall be responsible to pay any deductibles or co-payments owed at the time of services. I am responsible for payment within 90 days of the date of the service provided unless there is an contract the surgery center has signed that states otherwise.

By signing below, I consent to be contacted by regular mail, by email, or on my cell phone regarding any matter related to the above referenced by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes phone calls that employs auto-dialer technology and prerecorded messages. This consent applies to all healthcare providers covered under this agreement. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by certification mailing it to:137 25th St NE CLEVELAND, TN 37311-3944.

May we leave a message on your answering machine? □ Yes □ No List names of individuals we can leave a message with:_____.

TN requires us to report Race, it's used for health planning projects.

□ Am. Indian/Alaska Native □ Asian □Black(non-hispanic) □ Hispanic □ Multiracial □ Native Hawaiian/Pacific Islander □ Refused to self designate □ White □ White(no-hispanic)

Employer_____ Occupation_____ State of Birth_____

Is your surgery a result of a vehicle accident, personal injury with potential 3rd party liability/litigation/or other liability claim, or work related injury? □ Yes □ No

I understand if I do not reveal this information at time of services and it is discovered at a later date my insurance may be refunded and I (the patient or representative) may be billed the retail rate for the procedures.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I AM THE PATIENT, PARENT, LEGAL GUARDIAN OR AM DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

I UNDERSTAND AND AGREE THAT, AT THE TIME THE PATIENT HAS MET NOVAMED SURGERY CENTER OF CLEVELAND'S MEDICAL CRITERIA TO LEAVE THE FACILITY, I WILL HAVE A RESPONSIBLE ADULT PRESENT TO TAKE ME/PATIENT HOME. I RELEASE NOVAMED SURGERY CENTER OF CLEVELAND FROM ANY RESPONSIBILITY FOR EVENTS IN VIOLATION OF THIS AGREEMENT.

Signed **Witness** **Date** **Time**

Patient Notice Regarding Facility-Based Physicians Who are Out-of-Network

While receiving healthcare services at NovaMed Surgery Center of Cleveland, LLC d/b/a The Surgery Center of Cleveland, you may receive treatment from a facility-based physician who may be out-of-network and not have a current contract provider agreement with your insurer.

The physicians and other providers that may treat the patient at this facility may not be employed by this facility and may not participate in the patient's insurance network.

Anesthesiologists, radiologists, and pathologists are not employed by this facility. Services provided by those specialists, among others, will be billed separately.

The patient will be billed for additional charges, including out-of-network charges, if the patient is provided medical services by a healthcare provider that is not in-network. In particular, the patient should ask the facility if he or she will be provided any medical services by anesthesiologist, radiologists, or pathologist who are not in the patient's network.

Before receiving services, the patient should check with his or her insurance carrier to confirm if the patient's providers are in-network. Otherwise, the patient may be at risk of higher out-of-network charges.

NovaMed Surgery Center of Cleveland, LLC d/b/a The Surgery Center of Cleveland is contracted with the following physicians and/or physician groups to provide the following services:

Anesthesia

- Cleveland Anesthesia
  - [423]472-6513

Radiology

- N/A

Pathology

- Galen East Laboratory
  - 423-495-5764
  - www.galenmedical.com
- Associated Pathologist, LLC d/b/a PathGroup
  - 877-456-6706
  - www.pathgroup.com
- SouthEastern Pathology Services
  - 423-499-5033
- WATS Biopsy
  - 843-3697096
  - www.wats3d.com

By signing this notice, you agree to receive medical services by an out-of-network healthcare provider and will receive a bill for 100 percent (100%) of billed charges for the amount unpaid by your insurer

You will receive a separate estimate of the amount [FACILITY] will charge for items and services in accordance with your health benefits coverage including charges for items and services in excess of any cost sharing obligation that the insured would have if the facility were in-network.

Patient or Patient Representative Signature	*Date*
Patient or Patient Representative Signature	*Relationship to Patient*