Bascom Surgery Center
3803 S. Bascom Ave
Suite 106
Campbell, CA 95008
(408) 369-9535

BASCOM SURGERY CENTER
CONSENT FOR CONDITIONS OF ADMISSION AND RELEASE OF INFORMATION,

You may request copies at admission. Please initial <u>each</u> statement.

1. _____I acknowledge and understand my Patient Rights and Responsibilities.

2. _____ I have been informed of the Center's policies on advance directives or have been offered State advance directive forms.

3. _____ I understand that my physician may be an owner of the Center and that I have the right to choose another healthcare facility without repercussion.

4. _____ I hereby consent to the release and transfer of records if it becomes medically necessary to be transferred to hospital. I further consent to the release of the related discharge records to the Center upon discharge from that hospital.

5. _____ I hereby authorize direct payment to Center of any insurance benefits otherwise payable to me or on my behalf for the procedure(s) performed at the Center, at a rate not to exceed the Center's regular charges. It is understood by the undersigned that he/she is finally responsible for any charges not covered by this Assignment of Benefits consent. This Assignment of Benefits consent is valid for all insurance companies and programs, including Medicare.

6. _____ I authorize the Center to release medical information concerning the procedure(s) performed at the Center as may be requested by third party payors in order to process payment of my claim(s) in accordance with HIPAA regulations.

7. _____ I acknowledge that I am responsible for co-payments incurred on procedures that are cancelled yet deemed billable to the insurance carrier according to AMA (American Medical Association) guidelines. If a co-payment is collected and the procedure is cancelled and deemed non-billable according to AMA guidelines, the co-payment will be transferred to the rescheduled date of service or refunded.

8. _____ I have received a copy of the Financial Policies.

9. _____Consent to Telephone Calls for Financial Communications- With regards to services rendered and/or my related financial obligations, I expressly agree and consent that Silicon Valley Surgery Center and any associated affiliate / vendor providing quality improvement, customer service, billing or collection services may contact me by any method of contact (such as a telephone call utilizing an automated dialing device, dialing services, prerecorded message or texting) to any telephonic number that I have provided to the surgery center, or has been obtained by the surgery center or any of its associated affiliates / vendors or at a number forwarded or transferred from that number, including mobile telephone numbers.

YOUR SIGNATURE BELOW IS REQUIRED UPON ADMISSION TO THE CENTER.

_____
Patient (Please print) Date

_____ _____
Patient/Guardian/Surrogate Signature (indicate) Date

_____