North Fullerton Surgery Center
37 North Fullerton Avenue
Montclair, NJ 07042
Tel: 973-233-0433 Fax: 973-233-0144

Patient Label

Facility Consent Form

Patient's Name: _____ Date: _____

Physician's Name: _____

Consent for Treatment

I, the above-named and undersigned patient, give my consent for care at and by the medical, nursing allied professional staff of the above surgical center, which may include routine diagnostic procedures and such medical treatment as my doctor or his/her designees may find are needed. I acknowledge that no promises or guarantees have been made to me about the results of any examinations, treatments or procedures I may receive while at North Fullerton Surgery Center (the "Center").

Release of Medical Records

I authorize the Center to release all or any part of my medical record to (a) hospitals or medical service companies, insurance companies, workers' compensation carriers, welfare funds or other organizations or agencies that may be concerned with the payment of costs related to my treatment and (b) any other organization or agency to which the Center is permitted to release such information under applicable laws. In the event I am transferred or admitted to a hospital post-operatively, I authorize the Center to obtain a copy of the hospital discharge summary.

Utilization Review Appeal

I give my consent to the Center to pursue any and all appeals of my utilization managements determinations by my insurance carrier that result in a denial, termination or other limitation of covered health care services provided to me by the Center.

Financial / Insurance Agreement

Note that this Center **may not participate** in your medical insurance plan (s); in other words, this facility may be **"out of network"** for you. However, we will still submit a claim to your insurance company for our Center. **We will accept your out of network benefits but you will be responsible for applicable deductibles and coinsurance.**

Accordingly, if your insurance company sends the payment to you, please sign the back of the check and then send the check, along with a copy of the insurance company's explanation of benefits, to the Center. Please note that if your insurance company entirely denies payment of our fees, **you will be responsible for the full amount of any outstanding balance.**

Patient Agreement: In the event that my medical insurance pays less than the amount due for the services provided to me by the Center regardless of the reason(s) or should I fail to immediately send the Center my insurance company's check as described above, **I hereby agree that I am responsible for the full payment of the Center's fees outstanding for the services provided.**

Assignment of Benefits: I hereby authorize payment directly to the Center all insurance benefits specified and otherwise payable to me, but not to exceed the balance due on the regular charges. I understand that I am financially responsible to the Center for charges not covered by this authorization. Should the account be referred to collections after default, the undersigned agrees to pay costs of collection, including reasonable attorney's fee. All delinquent accounts have interest of legal rates.

Medicare Benefits: I request that payment of authorized benefits be made me on my behalf for any services furnished to me by the Center. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or those related services.

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Charges for Procedures: Professional fees for services provided by your doctor, anesthesiologist (in the case of cosmetic or self- pay this will be collected with the facility fee), pathologist, laboratory or other ancillary fees **are not** included in the Center's fees, and are billed separately by the respective providers. It is your responsibility to check with your insurance carrier regarding coverage of such services.

_____ _____

Patients or Parent / Guardian's Signature **Date** **Witness**

Patient Rights / Advanced Directives

I acknowledge that I have received a copy of the Patient's Rights and HIPAA Privacy Regulations. The Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed notice of privacy practices to help you better understand our policies in regard to your personal health information. The terms of this notice may change with time and we will always post the current notice at our Center, on our website, and have copies available for distribution.

I have received a copy of the Patient's Bill of Rights and have been informed that the Center DOES NOT HONOR an ADVANCE DIRECTIVE (Living Will, Durable Power of Attorney or Health care Proxy). The Center will forward a copy of my ADVANCE DIRECTIVE upon request, in the event that I require additional treatment at a higher level care facility.

I have an Advance Directive or Living Will:	☐ Yes	☐ No
I have brought an Advance Directive or Living Will with me:	☐ Yes	☐ No
I have requested and been given information and sample forms regarding Advance Directives and Living Wills	☐ Yes	☐ No

Clothing and Valuables

I fully understand that the Center is NOT responsible for any personal property (clothing, eyeglasses, dentures, etc.) brought in or retained in the lockers at any time. I fully understand that any valuables (money, jewelry, and keys) should be given to a family member or other responsible party for safekeeping.

Acknowledgement of Driving Risks

I understand that the procedure I will receive today may cause conditions that render driving unsafe. I have been informed by the Center that I should not drive for at least 24 hours after receiving the procedure and that I should not attempt to drive until my symptoms have resolved.

COMPLAINTS MAY BE LODGED WITH THE FOLLOWING

Administrator / Director of Nursing
Richard Salvia / Christine Salaterski, RN
North Fullerton Surgery Center
37 North Fullerton Avenue
Montclair, NJ 07042
973-233-0433

The Joint Commission
1 Renaissance Blvd.
Oakbrook Terrace, IL 60181
Complaint Hotline: 800-994-6610
http://www.jointcommission.org

NJ Department of Health & Senior Services
Division of Health Facilities Evaluation & Licensing
Trenton, NJ 08625
Complaint Hotline: 800-792-
http://www.state.nj.us/health/healthfacilities

Office of the Medicare Beneficiary
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244-1850
800-MEDICARE

Patient Label

Patient Signature

The undersigned certifies that this form has been fully explained to him/her, and the undersigned is satisfied that he/she understands its content and significance.

Signature of Patient	Date	Time	Witness

Representative/Guardian Signature

Patient is a Minor or unable to sign because _____.
The undersigned certifies that this form has been fully explained, and the undersigned is satisfied that the contents are understood. The undersigned certifies that he/she has been duly authorized by the patient as the patient's legal representative or guardian to execute the above and accept on behalf of the patient.

Signature of Representative / Legal Guardian	Date	Time	Witness