GRAND RIVER
SURGERY CENTER
LLC

AUTHORIZATIONS & DISCLOSURES

These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize any anesthesia, medical or surgical treatment, including services rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated, as may, in their professional judgment be deemed necessary or beneficial for the purposes of diagnosis, treatment and medical care at Grand River Surgery Center. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs, tissue, or body parts may be disposed of in accordance with accepted medical practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR REIMBURSEMENT: For purpose of reimbursement, Grand River Surgery Center and each attending or treating practitioner, including, but not limited to, pathology, anesthesia, radiology and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third-party reimbursement or which could otherwise be harmful or prejudicial to my interests.

AUTHORIZATION TO RELEASE MEDICAL AND PAYMENT INFORMATION TO SPECIFIC INDIVIDUALS: Grand River Surgery Center and each attending or treating practitioner are hereby authorized and directed, during my period of this admission, to disclose medical and payment information to my spouse, children, parents, and any other person authorized to consent to treatment pursuant to current state law, concerning my health status, diagnosis, prognosis, and progress.

Grand River Surgery Center is also hereby authorized and directed to disclose and discuss matters related to billing and payment **after** the period of admission. I do hereby release and hold Grand River Surgery Center, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss damage, or liability resulting from or arising out of such disclosures.

I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care to whom medical and payment information may be released:

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________ Please do not release my medical or payment information to any individuals.

RELEASE OF RESPONSIBILITY FOR VALUABLES: Grand River Surgery Center is hereby fully released from any and all responsibility for loss or damage to my personal property, money, or valuables.

NOTICE OF PRIVACY PRACTICES: I am aware of my rights to privacy of personal health information, under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and its amendments, and I have received a copy today upon my admission.

________ I acknowledge that I have received the Notice of Privacy Practices brochure
INITIAL

PHYSICIAN OWNERSHIP DISCLOSURE: Grand River Surgery Center provides services only to patients admitted by private practitioners who are members of the Medical Staff, some of whom have ownership of the surgery center. To determine if your physician has ownership of the surgery center, please review the list located in the lobby or check with Grand River Surgery Center personnel. I understand I may choose another facility for the services I require and have elected to receive care at Grand River Surgery Center.

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 Grand River Surgery Center will not perform my scheduled procedure unless these arrangements are met and have provided Grand River Surgery Center 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.

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Responsible Party Name Responsible Party Signature Phone Number

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at Grand River Surgery Center and I understand that the center's policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact) is to initiate resuscitative measures, should an adverse event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney. Please check one of the following:

- ○ YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record
- ○ YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me
- ○ NO, I do not have an Advanced Directive/Living Will/Health Care Proxy
- ○ I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to Grand River Surgery Center for any and all charges associated with the services rendered by Grand River Surgery Center, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Grand River Surgery Center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insurance carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all of the charges, Grand River Surgery Center will pursue the internal appeals provided by the health plan and will only bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Grand River Surgery Center bills both patients and health plans using the same fee schedule, and my financial obligation is based on my applicable benefit levels associated with services for which Grand River Surgery Center will bill my health plan pursuant to an assignment.
2. Insurance carriers are made aware of the surgery center's policy through disclosure on the claim form submitted to the insurer for services rendered. Detailed financial policies are available to the insurer upon request.
3. Grand River Surgery Center requests a portion or all, of my patient financial responsibility, on or before the date of service. Patient financial responsibility is determined based on the applicable patient portion of contractual rates, where a contractual agreement exists with the payor. Where contractual rates do not apply, Grand River Surgery Center will bill the patient for their financial portion, based on the patient's applicable benefit levels, once the claim has been processed, and appealed if necessary, and the allowable has been determined by the insurance company.

4. I am aware of my right to request a complete written estimate of the anticipated charges and my associated financial responsibility. I understand that the fee quoted to me, for the surgery facility, is an ESTIMATE only and it is possible that I will receive a bill for any balance which I remain financially obligated to pay.
5. Grand River Surgery Center will not waive any unmet coinsurance, deductibles or other patient responsibility associated with services for which it has billed a health plan pursuant to an assignment, except for reasons of financial hardship.
6. Grand River Surgery Center may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.
7. Patients with no insurance coverage will be eligible for a discount off charges in accordance with Grand River Surgery Center self-pay fee schedule.
8. Fees for anesthesia services, physician fees, pathology services, laboratory fees, durable medical equipment and surgical assistants, or other services rendered which are not included in the facility global rate will be billed separately where applicable.
9. I understand that if a payment is received by me, directly from the health plan that I have assigned to Grand River Surgery Center, I must endorse and forward the payment and Explanation of Benefits to Grand River Surgery Center as soon as the payment is received to avoid additional financial liability. **Failure to provide Grand River Surgery Center with payment made by my insurance carrier could result in the following:**

    ________ Alerting the proper authorities for insurance fraud and/or theft.
    INITIAL

    ________ Reporting to the IRS as income I have received.
    INITIAL

    ________ Collection proceedings or litigation.
    INITIAL

________ I acknowledge that I have read the above Notice of Financial Responsibility and understand and agree to
INITIAL Grand River Surgery Center terms set forth in this disclosure.

MEDICARE CERTIFICATION AND AUTHORIZATION: Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized by the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.

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NAME OF PATIENT

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SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY RELATIONSHIP DATE

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WITNESS DATE