TO ALL PATIENTS:

Please read, complete and sign the attached forms. These forms will become a part of you permanent medical record and therefore are required to be completed and brought with you the day of your procedure.

Please make sure to bring in a picture ID, your insurance card, and any required payment due at the time of service to the facility.

Be sure to follow your physician's instructions on preparing for your procedure. A nurse form the facility will also be calling within a couple days of your procedure with additional instructions to follow. Any instructions not followed could cause a delay or cancellation of your procedure.

PLEASE LEAVE ALL VALUABLES AT HOME. ONLY BRING YOUR ID, INSURANCE CARD, AND PAYMENT (IF APPLICABLE).

If you have any questions, please feel free to call us at 702-948-8894.

Thank you,

215 Surgery Center

6120 S. Fort Apache Rd., Suite 200 Las Vegas, NV 89148 Phone: 702-948-8894

PERSONAL INFORMATION

Patient Name: _____

SS#: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Ph#: _____ Cell Ph#: _____ Work Ph#: _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

SPOUSE/PARENT/RELATIVE INFORMATION

Name: _____ DOB: _____

Relationship to Patient: _____ Phone: _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____ DOB: _____

ID #: _____ Group #: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's SS#: _____ DOB: _____

ID #: _____ Group #: _____

Emergency Contact: _____ Phone #: _____

RELEASE OF MEDICAL INFORMATION: I hereby authorize the release of any or all medical information necessary to process insurance claims and request that the payment of all benefits be made to **215 Surgery Center** for services described. I also authorize the release of any medical records to other physicians/insurance companies/hospitals or **215 Surgery Center** for services needed in order to render necessary medical care pertaining to my services with **215 Surgery Center.**

_____ _____

Patient Signature Date

_____ _____

Signature of patient's represenative Date

PRE-ANESTHESIA QUESTIONAIRE

215 SURGERY CENTER

INSTRUCTIONS: Please indicate with checkmark as you answer each question. These answers will greatly help us give you the best possible care. If you do not know an answer please indicate by using a question mark. If there are multiple answers, please circle the appropriate one. Please be specific, and explain if necessary.

AGE _____ SEX_____ HEIGHT_____ WEIGHT_____

MEDICATION ALLERGIES_____REACTION _____

ARE YOU ALLERGIC TO LATEX ? YES___ NO___ Explain: _____

Have you or anyone in your family had any unusual reaction to anesthesia? YES___ NO___
Explain:_____

Are you taking any medications, including blood thinners (Aspirin, Ibuprofen, Plavix, Coumadin, Etc.)

_____

Are you taking any herbal medications? YES___ NO___
please list_____

	Yes	No
Have you had or do you still have ? If yes, when ?		
1 Are you diabetic ?	☐	☐
2 Do you have a cold ?	☐	☐
3 Bronchitis or chronic cough ?	☐	☐
4 Asthma ?	☐	☐
5 Emphysema ?	☐	☐
6 Shortness of breath ?	☐	☐
7 Any other lung trouble ?	☐	☐
if yes, explain:_____		
8 Do you smoke ? How much _____ day ?	☐	☐
9 Rheumatic Fever ?	☐	☐
10 Heart Murmur ?	☐	☐
11 Any heart valve problems ?	☐	☐
12 High Blood Pressure ?	☐	☐
13 Do you have a pacemaker? Rate_____	☐	☐
14 Chest pain/Angina ?	☐	☐
15 Heart Attack(s) ?	☐	☐
16 Palpitations: Irregular or fast heartbeat ?	☐	☐
17 Any blood disease ?	☐	☐
18 Jaundice, Hepatitis, Liver trouble ?	☐	☐
19 Gallbladder trouble ?	☐	☐
20 Do you drink alcoholic beverages?	☐	☐
How much alcohol/beer in a week? _____		
21 Gastric-esophageal problems ?	☐	☐
22 Reflux-frequent indigestion ?	☐	☐

	Yes	No
23 Seizure disorder ?	☐	☐
24 Hiatal Hernia ?	☐	☐
Neurological Problems ?	☐	☐
25 Stroke, Paralysis, severe head injury ?	☐	☐
26 Head or neck injury or surgery ?	☐	☐
27 Back trouble ?	☐	☐
If yes, for how long ? _____		
28 Kidney trouble ?	☐	☐
29 Thyroid trouble ?	☐	☐
30 Any history of street drug use ?	☐	☐
31 Have you had surgery before ? If yes, check list below		
☐ Appendectomy ☐ Hysterectomy		
☐ Breast/Biopsy ☐ Orthopedic_____		
☐ Cataracts ☐ Sinus/Nasal		
☐ Gallbladder ☐ Tonsils/Adenoids		
☐ Hernia ☐ Other		
32 Any illness or disease not listed ? _____		

Please list any information you feel would be helpful in your care:_____

_____

Date:_____

Phone Number: _____

Signature: _____

Physician signature: _____ Date: _____

Patient label

Medication Reconciliation

Patient Name _____ **Allergies** _____

	Medication Name	Dose	Frequency	Last taken Date	Route	Reason for taking
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Medication list reconciled, common side-effects and cautions reviewed with patient and/or their responsible party.A copy of this medication list will be given to patient upon request.

Reviewing Physician Signature/Date: _____

Patient Label

FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with highest quality surgical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON A CASE-BY-CASE BASIS
- FULL PAYMENT IS DUE AT TIME OF SERVICE, UNLESS ARRANGED OTHERWISE
- WE ACCEPT CHECKS, OR CREDIT CARDS (VISA, MASTERCARD, AMERICAN EXPRESS)
- WE ACCEPT MOST HEALTH SAVINGS ACCOUNT (HSA) PAYMENTS

Dishonored checks will be charged back to the patient's account with a service fee of $25.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred for collection.

Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, 215 Surgery Center will bill verifiable and assignable insurance. However, you will be personally responsible for your account balance whether or not your insurance will pay for the total balance of your claims, unless you are eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that **full payment prior to services being rendered is made** by providing a credit card or personal checking account with authorization to charge that amount for the balance due if your insurance company/employee benefits plan has not paid your account in full within 90 days or has determined your claims to be your responsibility for reasons including but not limited to annual deductible, co-payment, non-covered services, ineffective coverage at time of services, lack of pre-authorization and not medically necessary.

If a patient chooses or is required to bill his/her own insurance, 215 Surgery Center will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as self-pay.

Facility Charges

We will disclose to every patient our facility charges as clearly as practically possible before your procedure(s) if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities. As you may be aware, your insurance company requires your doctors to charge and bill their services separately from surgical facilities and hospitals. Therefore you may receive separate bills from your treating doctor, anesthesiologist, diagnostic labs, radiologist, pathologist, and others in addition to the surgical facility bills for your procedure. If you have any questions about your surgical facility bills, please direct them to us by contacting 702-948-8894.

We do not anticipate that you will require additional medical or surgical care in connection with the procedure(s) that you are requesting. Nonetheless, should you require additional medical or surgical care in the unlikely event of post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility (e.g., hospital expenses). The charges only include the stated date of services at this facility and do not include any other date of service from us or other providers and facilities.

PPO and HMO Network Participation

As you may know, you may have a choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing the highest quality care to every patient; however we have no power to change your insurance coverage or network limitations. Most health care plans or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at a lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you our participation status with your insurance plan.

At this time, we do not participate in any managed care networks other than Medicare Fee-for-Service Plans (Medicare Part B). Your health plan or insurance policy may include coverage for services you receive from out-of-network providers and facilities. However, please be aware that your plan or policy may cover a smaller portion of the cost of out-of-network provider services than it covers for the cost of in-network provider services.

As a courtesy to you, prior to your procedure we will verify your insurance coverage and obtain pre-certification, if applicable, for all services.

Please understand that your insurance carrier may take the position that insurance verification is not a guarantee of insurance payment.

Acknowledgement Regarding Disclosure of Beneficial Interest

By signing below, you acknowledge that your attending doctor(s) and/or clinic (facility) have disclosed to you at the time of initial contact and at the time of referral any significant beneficial interest they or their immediate family members might have in connection with the referral, including (A) his/her affiliation, if any, with the doctor or facility to whom you are being referred and (B) that he/she will receive, directly or indirectly, remuneration for the referral. This acknowledgement is made in connection with your right to informed consent and personal choice of doctors and facility based on the quality and safety of care, reputation of provider/facility and patient satisfaction. It is your responsibility to be knowledgeable in making decisions and exercising your rights with respect to the use of in-network or out-of-network coverage and your cost sharing responsibilities.

Doctor or Facility with significant beneficial interest: _____

By signing below, you further acknowledge that you may exercise your right of freedom of choice for the providers and facility under the in-network or out-of-network coverage as provided by your health plan, in compliance with all applicable federal and state laws, including without limitation Medicare, ERISA, PPACA and the State Business and Professions Code. You certify that you were informed of the effective alternative resources reasonably available at the time of your decision-making, and your option to use one of the alternative resources, and that you were assured by your attending physician that you will not be treated differently by the physician and his/her staff if you choose an alternative provider or entity.

By signing below, you certify that your decision to accept the referral made by your attending doctor(s) and/or clinic (facility) has been as the result of your informed choice for the quality and safety of the care that you will be expecting and receiving. Your decision is informed by, among other factors, the provider's professional reputation for providing quality and affordable healthcare that you personally expect under your health plan for out-of-network coverage.

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claims processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claims processing. You also agree to notify us immediately of any insurance inquiry or request for additional information, and will provide us with a copy of any documentation received from the insurance company or submitted to the insurance company from you.

In the event that you receive insurance payment check(s) for procedures rendered at 215 Surgery Center, you agree to submit such insurance reimburse check(s) to our facility within five (5) business days after your receipt of insurance check(s). In the event of a failure or refusal to forward or send us the insurance reimbursement check for the treatments from this provider, all your discount arrangement will be voided and your total balance is due immediately, as there is no justification for you to keep the insurance payment for our services, as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

Indigency Discount

We may offer medical indigency discounts to uninsured (Cash-Pay) and under-insured patients. We may also waive your cost-sharing amounts, deductibles, co-insurance and co-pay based on your individual medical needs and ability to pay, on a case-by-case, non-routine, unadvertised basis for under-insured patients, and after determining in good faith that you are in financial need. Unless expressly prohibited by any specific terms of the health plan, we are fully in compliance with the terms of the health plan and applicable federal and state laws under our Corporate Indigency Policy.

Once we have determined medical indigency, we will cease collection efforts against the patient with regard to the forgiven amount. However, our cessation of collection efforts shall not constitute an agreement that the patient has no financial or legal liability for the actual total charges, nor shall it in any way impair or be construed as an abandonment of the patient's legal assignment to us of his or her right and eligibility to claim reimbursement under the patient's health care coverage. Our patient advocate collection efforts are proactive with indigency determination and subsequent claims submissions and/or appeals. Any patient balance billing is only consequential to administrative and/or judicial appeal outcomes and subject to proactive patient indigency agreement.

You may apply for medical indigency discount assistance by asking our staff. We are committed to serving you with highest quality care possible at an affordable cost. Every staff at our facility is ready to help you at all times. If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation.

I have read, understand and fully agree to this Financial Policy. I hereby authorize the referral to non-participating and out-of-network provider(s) or entities as named above.

_____	X _____	Date _____
Patient Name	Patient Signature (or Guardian)	
_____	X _____	Date _____
Witness Name	Witness Signature	

_____

Name of Guardian, *if applicable*

Representations, Assignment of Benefits and Rights, and Designation of Authorized Representative

In consideration of the health care services to be rendered by 215 Surgery Center LLC ("Provider") to me, I hereby represent and agree as follows:

Information: All information I have provided to Provider in connection with the health care services to be rendered to me by Provider, including without limitation medical, financial, health care benefit plan, employee benefit plan, insurance coverage and worker's compensation and third party liability and claim information, as applicable, is accurate, complete and not misleading. I will promptly inform Provider of any change(s) in the information that I have given. A photocopy of this document is to be considered as valid as the original.

Financial Responsibility: Unless I am a Medicare or Medicaid beneficiary, I understand and agree that I am legally and fully financially responsible to Provider for all charges regardless of any insurance I may have, benefit plans, entitlement to worker's compensation benefits or third party liability and that these charges are my responsibility. I will promptly inform Provider of any change(s) in the information that I have given. All fees and services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance by myself or my health insurance carrier, and I agree to pay all such charges incurred in-full and immediately upon being billed. I understand and agree that I will be responsible for any attorney's fees and costs and/or collection fees and costs should it become necessary for Provider to take action to collect for its services and charges.

Authorization to Release Information: I hereby authorize Provider to release all medical information necessary to process my claims including to: 1) release any information necessary to insurance carriers regarding my illness and treatments; 2) to process insurance claims generated in the course of examination or treatment; and 3) to allow a photocopy of my signature to be used to process insurance claims. Further, I hereby authorize and instruct my insurance company, plan administrator, fiduciary, insurer, and/or attorney to release to Provider any and all any insurance policies, plan documents, description of coverage, summary benefit descriptions, benefit plan, explanation of benefits, audit or other information related to my insurance, benefits or other rights, as well as any personal injury settlement information upon written request from Provider or its attorney(s). This authorization will remain in effect until revoked by me in writing.

Assignment of Benefits: I hereby assign and convey directly to Provider all medical, surgical, and other health care benefits, insurance payments and any other payment or reimbursement for health care services rendered to me by Provider, regardless of its managed care network participation or contract status to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), benefit plan, insurer or other third party payer, including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Provider for health care services rendered to myself and/or my dependents. I understand and agree that if my benefit plan, insurer or other third party does not follow this directive and pays me for health care services rendered to me by Provider, I will immediately endorse and deliver to Provider, or otherwise cause to be paid to Provider, any such payment. Upon Provider's request, I will account to Provider for all amounts received and will deliver to Provider all explanation of benefits and other information I receive regarding such payments. I understand that I am responsible for any amount not covered by insurance.

Assignment of Claims: In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey directly to Provider, to the full extent permitted by law, including without limitation 29 U.S.C. sections 1132(a)(1) and 1132(a)(3), any legal, administrative or contractual claim or action arising under any group health plan, employee benefits plan, or health care insurance or third party liability insurance concerning medical expenses incurred as a result of the health care services, treatments, therapies, and/or medications I receive from Provider (including any right to pursue those legal or administrative claims or actions), and I designate Provider as my designated authorized representative. This constitutes and includes an express and knowing assignment of ERISA breach or fiduciary duty claims and any other statutory, regulatory, administrative, legal and/or administrative claims to Provider. I will promptly furnish information to, and otherwise cooperate reasonably with Provider, in its assertion of any such claim.

_____
Initials

I intend by this assignment and designation of authorized representative to convey to Provider all of my rights and powers to claim, or place a lien on, the health care benefits related to the services, treatments, therapies, and/or mediations provided by Provider, including rights to any settlement, insurance payments and reimbursement related to the services rendered to me by Provider, including any legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims), settlement proceeds or legal or administrative remedy.

As my assignee and/or designated representative, I grant to Provider the right to pursue said claims including the right to initiate, prosecute and defend to any claim, appeal, legal action or administrative proceeding in any federal, state or other forum and to (1) obtain information regarding the claim to the same extent as I am entitled; (2) conduct discovery and obtain and submit evidence; (3) make allegations and statements about facts or law; (4) make any request or motion including providing or receiving notices including notices of appeal proceedings; (5) assert in its own name as assignee or otherwise participate in any claim, appeal, legal, administrative and judicial actions or proceedings and pursue claims or chose in action or right against any insurer, liable party, insurance company, employee benefit plan, health care benefit plan, plan fiduciary, plan administrator, or any other party. Provider, as my assignee and my designated authorized representative, may initiate any lawsuit, legal action or administrative proceeding, against any insurer, health care benefit plan, employee benefit plan, plan administrator or insurance company or other responsible party in my name with derivative standing at Provider's expense.

I intend for these agreements, assignments and designations to conform to all applicable laws and regulations regarding the subject matter. Any non-conforming provision shall be deemed severed, and the remaining provisions shall remain in full force and effect. The headings and captions in this agreement and document are intended solely for convenience of reference only, and shall be given no effect in its construction or interpretation. Unless revoked, this assignment is valid for all administrative and legal proceedings and judicial reviews under Patient Protection and Affordable Care Act (PPACA), ERISA, Medicare, Medicaid and applicable federal and state laws and regulations. A photocopy or facsimile or other electronically transmitted image of this assignment is as valid as if it was the original.

If Provider prevails in any action or proceeding to enforce any provision of the foregoing representations, assignment and designation of authorized representative, the Provider shall be granted and recover its attorney's fees and costs.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT AND AGREE TO IT AND AGREE TO BE HELD LEGALLY ACCOUNTABLE TO PROVIDER FOR ALL BILLS. I have also asked any questions I may have prior to signing.

_____
Date

_____ _____
Patient Name | Last 4 numbers of patient's social security number.

_____ _____
Responsible Party Name (if patient is under 18 years of age or has no insurance) | Guardian Name (if patient is under 18 years of age)

_____ _____
Patient/Responsible Party Signature | Guardian Signature (if patient is under 18 years old)

Relationship to Patient: _____