Surgicore, LLC
444 Market Street
Saddle Brook, NJ 07663
Ph: (201) 843-9441 Fax: (201)843-9442

AUTHORIZATION TO RELEASE INFORMATION AND PAY FACILITY/ANESTHESIOLOGIST DIRECTLY

1. I authorize Surgicore, LLC to release to appropriate third parties such information as may be necessary, including my diagnosis, and other information from my medical records for the purpose of processing my facility and/or Anesthesia claims(s) ("bills").
2. I authorize all health insurance payments for services rendered to be sent directly to Surgicore, LLC and/or the Anesthesiologist; these amounts shall not exceed the balance of the facility and/or anesthesiologist's charges fir these services. This is a direct assignment of my insurance policy.
3. I understand that I am financially responsible to the facility/anesthesiologist for all charges not covered by insurance. I understand that I or my insurance company may receive more than one charge originating from different sources for this procedure. For example, separate fees may originate in addition to the physician's fee and will be billed separately (i.e. radiology, anesthesiology, facilities, and laboratory fees).
4. I acknowledge that the insurance information I have provided is accurate and true.
5. I understand that in the event of an emergency or the need for extended care; I may be transferred to a hospital, or may need to seek treatment at an Emergency Room, Rehab Facility or LTC Provider. In any case, I authorize Surgicore, LLC to obtain a copy of my medical record so as to provide the Center with appropriate follow-up information.
6. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct and I authorize Surgicore, LLC and/or the Anesthesiologist to release to the Medicare Bureau, CMS, and/or its intermediaries or carriers any information about me needed for this claim including any medical information relating to my treatment.
7. I understand that I should not bring any valuables to the surgery center and that the surgery center is not liable for the theft or loss of any valuables.
8. I understand that the Physician who is rendering services has an ownership interest in Surgicore, LLC and that I have the option to be treated at another facility. I wish to be treated at the above reference facility.
9. A copy of the Patient's Rights and Responsibilities has been offered to me or to my representative.
10. A copy of the HIPAA Notice of Privacy for the Center has been offered to me or to my representative.
11. I understand that with the exception of local anesthesia, a patient's representative must be present to drive me home from the center after surgery and whose care I will be under for the next 24 hours.

ADVANCE DIRECTIVE WAIVER

12. I acknowledge that I have been given the opportunity at least 24 hours in advance of my admission to review facility's policy regarding Advance Directives published on the facility's website.
13. Some of the procedures and medications used during your surgery could be similar to procedures and mediations specified in Advance Directives. Therefore to insure the best possible care during your surgery you MUST waive your Advance Directives during your admission to the center.
14. I acknowledge that all resuscitative measures will be taken during my stay at the center and I further understand that if I have ever signed an "Advance Directive", I temporarily waive it in it's entirely for the duration of my visit at the surgery center.

By signing here, I agree to all 14 (fourteen) authorizations on this page.

PATIENT SIGNATURE DATE

PATIENT/GUARDIAN/REPRESENTATIVE
(If patient is unable or too young to sign) RELATIONSHIP TO PATIENT

PRINT NAME WITNESS

ASSIGNMENT OF BENEFITS & AUTHORIZATION

TO PURSUE APPEAL AND/OR DENIAL OF PIP BENEFITS

_____ [Patient Name]

_____ [Insurer]

_____ [Claim #]

In consideration of the professional services rendered by _____ ("Health Care Provider") I, hereby irrevocably direct, authorize, assign and consent to the following:

1) The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for PIP insurance benefits with regard to the above-captioned claim to Health Care Provider, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claims.

2) The authorization of Health Care Provider to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim.

3) The authorization of Health Care Provider to initiate and prosecute any and all appeals and/or arbitrations or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer as well as NAF PIP arbitrations.

4) The authorization of Health Care Provider to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.

5) The authorization of Health Care Provider to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.

6) The authorization for payment of any and all PIP insurance benefits directly to Health Care Provider to which I might be entitled under the above-captioned claim.

PATIENT:

Signature: _____

Date: _____

WITNESS:

Signature: _____

Original on file

Surgicore, LLC
444 Market Street
Saddle Brook, NJ 07663
Ph: (201) 843-9441 Fax: (201)843-9442

PIP Ledger

I, _____, hereby authorize SURGICORE, LLC to obtain a PIP Ledger from my insurance company, on my behalf, in order to seek benefits information.

Patient signature: _____ Date: _____

Notice of Facility Lien

PATIENT : _____

DATE OF ACCIDENT : _____

I do hereby authorize Surgicore, LLC to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said facility such sums as may be due and owing said facility for medical service rendered to me both by reason of this accident and by reason of any other bills that are due the facility and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said facility. And, I hereby further give a lien on my case to said facility against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted by said facility for services rendered to me and that this agreement is made solely for said facility's additional protection and in consideration of the facility awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said facility of any change or addition of attorney(s) used by me in connection with this accident; and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the facility. I have been advised that if my attorney does not wish to cooperate in protecting the facility's interest, the facility will not await payment but may declare the entire balance due and payable.

Dated: _____ _____

CLIENT

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said facility above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Dated: _____ _____

ATTORNEY

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURING ON AND AFTER 3/1/02)

I, _____ ("Assignor") hereby assign to Surgicore LLC, ("Assignee"),all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The assignee hereby certifies that they have not received any payment from or on behalf of the assignor and shall not pursue payment directly from the assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY ANS WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWLING MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITIS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO ANY LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE AVLUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIMS FOR EACH VIOLATION.

_____ _____

(Patient Signature) (Date)

Surgicore, LLC

(Name of Provider)

_____

(Provider's Signature)

_____

(Date)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
HOSPITAL FACILITY FORM

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIM REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

1. INSURANCE COMPANY	2. ADDRESS OF INSURANCE COMPANY	
3. PATIENT'S NAME AND ADDRESS	4. DATE OF BIRTH	5. PHONE NUMBER
6. AUTOMOBILE POLICY NUMBER	7. NAME AND ADDRESS OF POLICYHOLDER	
8. ACCIDENT DATE	9. ADMISSION DATE	10. DISCHARGE DATE

11. PLACE OF ACCIDENT

12. DESCRIPTION OF ACCIDENT

13. IDENTITY OF VEHICLE OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:
OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	YES	NO
14. WAS PATIENT THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WAS PATIENT A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WAS PATIENT A PEDESTRIAN?	☐	☐
WAS PATIENT A MEMBER OF THE POLICYHOLDER'S HOUSEHOLD?	☐	☐

15. ADMITTING DIAGNOSIS:

16. DISCHARGE DIAGNOSIS:

17. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐

18. WAS TREATMENT RENDERED SOLELY AS A RESULT OF INJURIES ARISING OUT OF THE ABOVE ACCIDENT? YES ☐ NO ☐
IF NO, PLEASE EXPLAIN.

19. OPERATIONS OR PROCEDURES PERFORMED (NATURE AND DATES):

20. ATTACH REPORT OF SERVICES RENDERED AND ITEMIZED BILL	HOSPITAL CHARGES MUST BE COMPUTED IN ACCORDANCE WITH RATES PERMITTED BY SECTION 5108 OF THE NEW YORK INSURANCE LAW AND INSURANCE REGULATION NO. 83.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

TAKEN BY: _____ PRINT NAME _____ TITLE & PHONE NO.

_____ SIGNATURE _____ DATE

DATE TAKEN FROM RECORDS: _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
HOSPITAL FACILITY FORM - PAGE 2

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THIS ACT. THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE PATIENT AS TRUE UNDER THE PENALTIES OF PERJURY.

_____ _____
(SIGNATURE OF PATIENT, PARENT OR GUARDIAN) (DATE)

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (Authorization to Pay Benefits) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item A of this form.

A. _____ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN ITEM B).

AUTHORIZATION TO PAY BENEFITS:
I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

SIGNED _____ SIGNED _____
(SIGNATURE OF PATIENT, PARENT OR GUARDIAN) (SIGNATURE OF HOSPITAL REPRESENTATIVE)

_____
DATE

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in item B or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

B. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #A ABOVE).

ASSIGNMENT OF NO-FAULT BENEFITS:
I, HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED ABOVE ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

SIGNED _____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN (Assignor) DATE

_____ SIGNED _____
(HOSPITAL NAME - Assignee) (HOSPITAL REPRESENTATIVE)

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

NYS FORM NF-5 (Rev 6/2013)

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

_____ _____
SIGNATURE (PATIENT, PARENT OR GUARDIAN) DATE

SURGICORE, LLC
444 Market Street
Saddle Brook, New Jersey 07663
(201) 843-9441 Fax: (201) 843-9442

ADVANCE DIRECTIVE-LIVING WILLS

Do you have an Advance Directive or Living Will? Yes No

If yes, do you have a copy with you? Yes No

If no, who has a copy? Name:_____ Phone #:_____

New Jersey State law mandates that all health care facilities ask the patient whether he/she has an Advance Directive or Living Will. Medicare has also asked ambulatory surgical centers to provide the patient or the patient's representative with information concerning its policies on advance directives prior to the procedure, including a description of applicable state health and safety laws and, if requested, official state advance directive forms.

If you have an Advance Directive or Living Will, please bring a copy of it with you to the center on the day of your surgery.

An Advance Directive or Living Will is used by an individual to indicate their voluntary, informed choice of accepting, rejecting, or choosing among alternative courses of medical treatment.

An Advance Directive or Living Will is a document which allows you to give written instruction to those caring for you indicating the type of health care you would wish to receive or reject in the event you become unable to express these decisions yourself.

There are three different types of Advance Directives:

1. A Proxy directive:
   This is a document in which a competent adult names a trusted relative or friend to make health care decisions on his/her behalf when he/she is unable to make these decisions.

2. An Instruction Directive:
   In this document, the person writing it provides written instructions concerning the type of medical treatment they want or do not want performed for them and under what circumstances.

3. A Combined Directive:
   In this document, a competent adult state his/her general wishes regarding the kind of health care he/she wishes to receive, but appoints a trusted relative or friend to carry them out.

A brochure containing Living Will information is available from the Division of Aging. If you wish to receive the brochure, please make your request to the center or request this information from the address below:

The Division of Aging
101 South Broad Street
CN 807
Trenton, New Jersey 08625

PLEASE NOTE: IT IS NOT THE POLICY IF THE SURGICAL CENTER TO ACKNOWLEDGE ADVANCE DIRECTIVES IN THE CENTER. IF YOU WISH AN ADVANCE DIRECTIVE WILL BE PLACEED IN YOUR CHART TO BE USED IN EVENT OF ATRANSFER TO A HOSPITAL WHERE YOUR ADVANCE DIRECTIVE WILL BE ACKNOWLEDGED.

X_____ _____
PATIENT SIGNATURE DATE

SURGICORE SURGICAL CENTER, LLC

Patient Acknowledgement of Rights and Responsibilities

I acknowledge being given a copy of the Bill of Rights enforced at Surgicore Surgical Center, LLC. I have read the Patient Bill of Rights and Responsibilities.

I understand that if I have executed an Advance Directive, I should bring it with me on the date of my admission. However, I further understand that if I have signed an Advanced Directive I MUST Waive IT, in its entirety for the duration of my visit to the surgery center. I acknowledge, I have been informed of this policy at the time of my admission to the surgery center.

I further, understand that my physician may have a financial interest or ownership in the Surgical Center and I may choose to have my procedure or surgery done at another facility. I acknowledge that I have been informed of this.

I also understand if I do not sign this document on the date of my admission, I will be asked to sign a replacement.

X_____ _____

PATIENT SIGNATURE DATE

SURGICORE, LLC
444 Market Street
Saddle Brook, New Jersey 07663
(201) 843-9441 Fax: (201) 843-9442

CERTIFICATION OF TRANSPORTATION

I, _____, certify that I have no means of transportation for my scheduled procedure at this facility. At this time, I required transportation services from Surgicore, LLC in order to undergo my surgery.

Signature: _____ Date: _____

PROGRESSIVE-HUDSON ANESTHESIA, LLC

P.O. Box 1658, Hoboken, NJ 07030

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charges to the patient and are due at the time of service, unless the patient has insurance of some type or other self-pay arrangements have been made in advance with our business office. Necessary registration forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I herby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I herby authorized and direct my insurance carrier(s), including Medicare, private insurance and any other health, medical, Personal Injury, or Worker's Compensation plan, to issue payment check(s) directly to ***Progressive-Hudson Anesthesia, LLC*** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I herby authorized ***Progressive-Hudson Anesthesia, LLC*** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from ***Progressive-Hudson Anesthesia, LLC*** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I will cooperate to the full extent necessary to permit ***Progressive-Hudson Anesthesia, LLC*** to receive and collect payment(s) from my insurance carrier. If the insurance carrier sends payments directly to me I will sign over and forward this and any future payments received in full to ***Progressive-Hudson Anesthesia, LLC*** for payment of services rendered. Any attempt by me to not cooperate or abscond with these payments will result in collection efforts and/or derogatory reports to my credit report, and may include formal legal suit, the charges of which will be added to the original insurance payment(s) received.

A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

PATIENT RESPONSIBILITIES

In order to provide you, the patient, with the optimal quality of care, we ask that you comply with the following responsibilities:

1. You, or your family, will provide information about past illnesses, hospitalization, medication and other matters relating to your health history.

2. You will cooperate and follow the care prescribed or recommended for you by your physician, nurses, or allied health personnel.

3. You will notify your physician or nurse if you do not understand your diagnosis, treatment or prognosis.

4. You will advise your nurse, physician, or the nurse manager of any dissatisfaction you may have regarding your care at the facility.

5. You will assume financial responsibility for services rendered, either through third party payors (your insurance company) or through self-payment for services not covered by your insurance company.

6. You will not take drugs which have not been prescribed to you by your attending physician and administered by the staff; and you will not complicate or endanger the healing process by consuming alcoholic beverages or toxic substances during your stay.

7. You will abide by the facility rules and regulations and be considerate of the rights of other patients and facility personnel.

8. You will be courteous to the treating staff.

PATIENT RIGHTS

Surgicore Surgical Center does not discriminate with regard to race, color, religion, gender, National origin, citizenship status, ancestry, age, disability or any other legally publicized status.

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;

2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third party payment or not covered by the facility's basic rate;

3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;

4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected results. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;

5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;

6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule, and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;

7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination or reprisal;

8. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;

9. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;

10. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;

11. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;

12. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient; and

13. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.

14. To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care in accordance with N.J.A.C. 8:43 E-6

15. If there are any problems or concerns please call the Department of Health directly at 1-800-792-97