Surgicore Surgical Center, 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 Sugricore Surgical Center, 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 claim(s) ("bills").
2. I authorize all health insurance payments for services rendered to be sent directly to Surgicore Surgical Center, LLC and/ or the Anesthesiologist; these amounts shall not exceed the balance of the facility and/ or anesthesiologist's charges for 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 Surgical Center, 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 Surgical Center, 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 Surgical Center, 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 oppertinuty at least 24 hours in advance of my admission to review faclity'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 medications 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 "Advanced 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 under 18) Relationship to Patient

_____ _____

Print Name Witness

A

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

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 SURGICAL CENTER LLC

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name: _____

Insurance Plan: _____

Member ID: _____

Date of Services: _____

The undersigned patient _____ ("Patient") hereby agrees to pay SURIGCORE SURGICAL CENTER ("Provider") the full amount charged for any and all services furnished to me or my dependent, without any offset whatsoever.

Solely as a courtesy to Patient, Provider will bill any applicable insurance company. However, Patient understands that his/her insurance company may only cover a portion, if any at all, of the total amount due for services rendered. Irrespective of any payment, Patient hereby agrees that he/she is financially responsible to Provider for any and all charges and services not covered by Patient's insurance company, including, but not limited to any co-payments or deductibles.

Furthermore, in the event that Patient's insurance company fails to reimburse Provider for services rendered and, instead, provides reimbursement directly to Patient, Patient hereby agrees that he/she will remit any and all reimbursed amounts to Provider immediately, but in no event later than three (3) days after Patient's receipt of such amounts.

In the event that legal action is required to enforce payment for services rendered to Patient, Patient hereby agrees to pay all court costs, expenses, attorneys' fees, and other costs incurred and/or expended as a result of such proceeding.

In addition, Patient acknowledges and agrees that the terms and conditions in this Patient Financial Responsibility Form as outlined above shall be effective for continuing and additional services incurred after execution of this form.

Patient's obligations under this Patient Financial Responsibility Form shall cease only when full payment has been made to Provider for services rendered to Patient.

Patient hereby acknowledges that he/she has read, understands, and agrees to all of the above terms and conditions. Patient further acknowledges that he/she has received a completed and signed copy of this Patient Financial Responsibility Form.

_____
Patient Name (please print)

_____
Patient Signature

_____
Date

_____
Witness Name (please print)

_____
Witness Signature

_____
Date

SURGICORE SURGICAL CENTER

PATIENT FINANCIAL RESPONSIBILITY FORM - ADDENDUM

PATIENT'S DUTY AND RESPONSIBILITY TO DELIVER ALL CHECKS AND/OR PAYMENTS RECEIVED

I, _____, HEREBY AGREE, ACKNOWLEDGE, AND WARRANT THAT I WILL PERSONALLY DELIVER ANY AND ALL CHECKS AND/OR PAYMENTS PROVIDED TO ME BY MY INSURANCE COMPANY IN CONNECTION WITH SERVICES FURNISHED TO ME AND/OR MY DEPENDENT BY SURGICORE SURGICAL CENTER ("PROVIDER").

IN ADDITION, I HEREBY UNDERSTAND AND ACKNOWLEDGE THAT IF I FAIL TO DELIVER SUCH CHECKS AND/OR PAYMENTS TO THE PROVIDER IMMEDIATELY, BUT IN NO EVENT LATER THAN THREE (3) DAYS AFTER RECEIPT OF THE SAME, A COLLECTION ACTION WILL BE COMMENCED AGAINST ME, PURSUANT TO WHICH I WILL BE PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL AMOUNTS CHARGED BY THE PROVIDER, AS WELL AS, ANY AND ALL COURT COSTS, EXPENSES, ATTORNEYS' FEES, AND OTHER COSTS INCURRED AND/OR EXPENDED AS A RESULT OF SUCH COLLECTION ACTION.

_____
Patient Name (please print)

_____
Patient Signature

_____
Date

_____
Witness Name (please print)

_____
Witness 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

Surgicore Surgical Center, LLC

444 Market Street, Saddle Brook, NJ 07663

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged 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 hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health, medical, Personal Injury, or Worker's Compensation plan, to issue, to issue payment check(s) directly to Surgicore Surgical Center, 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 hereby authorize Surgicore Surgical Center, 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 Surgicore Surgical Center, LLC on behalf of myself and/ or my dependents, and understand that by making this I 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 Surgicore Surgical Center, LLC to receive and collect payment(s) from my insurance carrier. If the insurance carrier sends payment directly to me I will sign over and forward this and any future payments received in full to Surgicore Surgical Center, 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

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