PACIFIC SURGERY CENTER, LLC

Authorization for Medical Treatment: I do hereby acknowledge, agree and give my consent for diagnosis, treatment, therapy sessions, and/or admission at Pacific Surgery Center as may be deemed necessary or desirable by my treating physician(s), their assistants and /or designees. This Authorization includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory tests, and x-rays. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating physician(s) and the Facility will follow the instructions of my physician(s) in the provision of said care.

Patient Rights: I, the undersigned, have received a separate document informing me of my rights and responsibilities as a patient.

Personal Valuables: I understand that the Facility maintains a keyed locker for the safekeeping of money and valuables. I understand that, except for such money and valuables which I deposit with the Facility for safekeeping, the Facility shall not be liable for the loss or damage of my personal property. I accept full responsibility for all property kept in my possession.

Assignment of Facility Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to the Facility and authorize direct payment to the Facility. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Assignment of Professional Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to all physician(s) and/or medical professionals providing services to me and authorize direct payment to physician(s). This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Authorized Representative: I hereby authorize the Facility, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by the Facility.

Statement of Responsibility: I understand that I am financially responsible to the Facility as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, and any out-of-pocket expenses. I authorize the Facility or physician(s) to access and review my credit report for purposes related to billing or collection of accounts payable to the Facility or physician(s). By providing us with your landline or cell phone number(s), you give your consent to any of Pacific Surgery Center operations or independent business partners who do work on Pacific Surgery Center's behalf, including our billing and collection agents, to contact you at these numbers, or, at any number that is later acquired for you, and, to leave live, or prerecorded messages regarding any accounts or services. For greater efficiency, these calls may be delivered by an auto dialer. However, providing us a landline or cell number is not a condition of receiving our services.

Authorization to Release Information to Insurance Company/Third Party Payor: I hereby authorize the Facility, any authorized healthcare provider, including Veteran's Administration or governmental hospital, any insurance company or any other person, institution, or organization to release my medical record to any person, corporation, workers' compensation carrier, governmental agency (or representative thereof) which is, or may be, liable under any contract or governmental program to this Facility, the patient, or a family member for all or part of the Facility's charge. This Facility will endeavor to protect the confidentiality of my medical records. However, this Facility shall not be liable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release.

Non-covered Medicare/Medicaid Services: The Medicare and Medicaid Programs have certain inpatient, outpatient and observation hospital admissions that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical chart indicates my admission is for any of the foregoing treatments.

Please initial: _____ I acknowledge receipt of Pacific Surgery Center Health's Notice of Privacy Practices.

Please initial: _____ I acknowledge that I was provided with information about my patient rights and responsibilities.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent or is duly authorized by or on behalf of the parent to execute the above and accept its terms.

Patient's Signature/Parent if Minor/Power of Attorney/Guardian	Relationship	Date
Responsible Party's Signature (If Not Same as Patient or Parent)	Insured's Signature	
Witness to Signatures	Patient Unable to Sign Consent Because	