Methodist MANSFIELD AMBULATORY SURGERY CENTER

ADMISSION ACKNOWLEDGEMENTS

ADVANCE DIRECTIVES:

Methodist Mansfield Ambulatory Surgery Center respects the right of patients to make informed decisions regarding their care. Please note that our Facility's policy on Advanced Directives is that Life sustaining efforts will be initiated, and the patient will be transferred to a higher level of care facility where their Advance Directive may be enacted. If you would like information on developing Advanced Directives, please ask and information will be provided to you.

____I have an Advance Directive
- _____ I have presented a copy to MMASC
- _____I did NOT present a copy to MMASC

____I do NOT have an Advance Directive
- _____I would like information about Advance Directives
- _____I do NOT want Advance Directive information
- _____I received Advance Directive information

____I have a Medical Power of Attorney

_____(Initials) I understand it is my responsibility to provide a copy of my advance directives to the Center.
(*Center Staff Note: Shaded area indicates that advance directive follow-up documentation is required.)

_____(Initials) **PATIENT RIGHTS AND RESPONSIBILITIES:** I have received written information regarding my rights and responsibilities as a patient. This information tells me how to register complaints I might have.

_____(Initials) **MY VALUABLES:** I understand that the Center does not assume responsibility for personal property I may keep with me during my treatment/Surgical Procedure. I understand that unnecessary items should be sent home.

_____(Initials) **MEDICATIONS:** If I have personal medications with me, I understand that I may not take them but will give them to a family member.

FINANCIAL AGREEMENT & ASSIGNMENT OF INSURANCE BENEFITS

In consideration for the services rendered to the above-named patient, the undersigned hereby individually obligates him/herself to the account of the Center in accordance with Center regular rates and terms regardless of whether insurance payments are available or made on my behalf. In the event it should be necessary to refer the account to any attorney or collections agency for collection, I hereby agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts, at the Center's option, bear interest at the legal rate. Until my account(s) are finally settled, I give my direct consent to receive communication regarding my account(s) from any servicers and any collectors of my account(s), through various means such as 1) any cell, land line, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications. In consideration of services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits to the above-named Center otherwise payable to me for this admission. I transfer and assign all rights, title and interest in the above-named insurance policy and any payment due me to the above-named Center. I understand and agree that I am responsible for providing any information required by my insurance company and agree to follow those pre-admission and pre-authorization guidelines that the insurance company may require. I understand that I am financially responsible for all charges which are not covered by the insurance, including, but not limited to, co-pays, deductibles, charges in excess of policy coverage, and limitations or exclusions of coverage.

Physician providing services: I understand that physicians, including my admitting physician as well as others, such as Pathologists, Radiologists or Anesthesiologists, who may provide diagnosis, care, or supervision of tests while I am in MMASC will bill me separately from the Center, and that some or all of these may not be covered by the same health plans as the Center, and I will be responsible for paying these physicians, subject to the terms of whatever health plan or insurance I may have.

If the person signing this form is not the patient, please give full name, phone number and address:

_____

I have read and understand this information.

_____ _____ _____ _____

Signature of patient or legally authorized Representative* | Relationship to Patient | Reason Patient Unable to Sign | Date/Time of Signature

_____ _____ _____

Witness | Title | Date/Time of Signature

Patient Label