

AUTHORIZATIONS & DISCLOSURES

These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

AUTHORIZATION FOR MEDICAL TREATMENT: The undersigned hereby authorizes any anesthesia, medical or surgical treatment, including services rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated, as may, in their professional judgment be deemed necessary or beneficial for the purposes of diagnosis, treatment and medical care at Michigan Outpatient Surgical Solutions (MOSS). NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: For purpose of reimbursement, MOSS and each attending or treating practitioner, including, but not limited to, pathology, anesthesia, radiology and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third party reimbursement or which could otherwise be harmful or prejudicial to my interests. Unless specifically instructed otherwise, MOSS and each attending or treating practitioner are hereby authorized and directed, during the period of this admission, to disclose information to the patient's spouse, children, parents, and any other person authorized to consent to treatment pursuant to 431.061-.065, RSMO (1979) as amended, concerning the patient's health status, diagnosis, prognosis, and progress. Each of the undersigned do hereby release and hold MOSS, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss damage, or liability resulting from or arising out of such disclosures.

RELEASE OF RESPONSIBILITY FOR VALUABLES: MOSS is hereby fully released of and from any and all responsibility for loss or damage to the personal property, money, or valuables of the undersigned patient.

NOTICE OF PRIVACY PRACTICES: I am aware of my rights to privacy of personal health information, under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and am aware that a copy of these rights are available to me upon request.

RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received, prior to my procedure, a copy of the Patient Rights and Responsibilities, which includes information regarding where and how I can file a grievance or complaint.

PHYSICIAN OWNERSHIP DISCLOSURE: MOSS provides services only to patients admitted by private practitioners who are members of the Medical Staff, some of whom retain joint ownership of the surgery center. I understand I may choose another facility for the services I require, and have elected to receive care at MOSS. Our owners: Dr. Ronald Adelman DPM, Dr. Michael Brager MD, Dr. Amir-Kianoosh Fallahi MD, Dr. Martin Jenter DO, Dr. Elie Khoury MD.

TRANSPORTATION RELEASE: I understand that the anesthetic to be administered to me may have effects that make it hazardous for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. I understand that MOSS will not perform my scheduled procedure unless these arrangements are met, and have provided MOSS with my designated responsible party's name and phone number

NOTICE OF FINANCIAL RESPONSIBILITY: Michigan Outpatient Surgical Solutions (MOSS) is committed to meeting the healthcare needs of all patients in a state of the art environment, with first rate staff and excellence in patient satisfaction. MOSS may not be a participating provider with all insurance plans, but we strive to give patients and insurers the best possible value for their healthcare dollar, providing access to superior quality care to all patients in the community, regardless of insurance type, at a cost-effective rate. Financial responsibility for patients and insurers will be calculated in accordance with any existing contractual agreements in effect on the date of service, pursuant to an assignment of benefits provided by the patient. In the absence of applicable contractual rates*, such as services rendered to patients holding insurance coverage for which the surgery center is not a participating provider, the following policies will apply.

1. The surgery center bills both patient and health plan using the same fee schedule.
2. The surgery center requests a deposit on the date of service, which will be applied to the patient's total financial responsibility.
3. Patient responsibility is determined based on the applicable patient portion of contractual rates, where a contractual agreement exists with the payor. Where contractual rates do not apply, surgery center will bill the patient for their financial portion once the claim has been processed, and appealed if necessary, and the allowable has been determined by the insurance company.
4. Upon registration, patients will sign the relevant financial documents, including the Assignment of Benefits, Authorizations & Disclosures and Acknowledgement of Financial Policies.
5. The surgery center will not waive any unmet coinsurance, deductibles or other patient responsibility associated with services for which it has billed a health plan pursuant to an assignment, except for reasons of financial hardship.
6. The surgery center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received, reviewed and processed by the insurance carrier.
7. Verification of benefits is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan in effect at the time of service. Financial obligation is based on applicable benefit levels associated with the services the surgery center provides.
8. Fees for anesthesia services, physician fees, pathology services, laboratory fees, durable medical equipment and surgical assistants, or other services rendered which are not included in the facility global rate will be billed separately where applicable.
9. When a health plan denies some or all of the charges, the surgery center will pursue the internal appeals process provided by the health plan, and patient responsibility will be billed after the appeal.
10. Final patient responsibility is determined based on the allowed amount of the claim as listed on the insurance company Explanation of Benefits, once processed by the insurance carrier, and the patient's applicable benefit levels.
11. Patients are informed that estimates of financial responsibility are subject to change based on procedures performed or determination of coverage, and that they remain financially obligated for any and all charges associated with services rendered.
12. Patients with no insurance coverage will be considered self-pay, and will be eligible for the 70% prompt pay discount off charges.
13. When patients receive payment directly from the health plan, patients must endorse and forward the payment and Explanation of Benefits to Michigan Outpatient Surgical Solutions within 5 days of receipt to avoid additional financial liability.
14. Insurance carriers are made aware of the surgery center's discount policy through disclosure on the claim form submitted to the insurer for services rendered.

**Contractual rates include, but are not limited to, government set fee schedules for Medicare, Medicaid, TriCare, Worker's Compensation, other government mandated fees, Third Party Agreements, direct employer or patient agreements, and Managed Care contracts.*

MEDICARE CERTIFICATION AND AUTHORIZATION: Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized by the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.

NAME OF PATIENT

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & RELATIONSHIP
FINANCIALLY RESPONSIBLE PARTY

DATE

WITNESS

DATE