ADVANCED REGIONAL
Surgery Center, LLC

Permanent Medical Record Completion Checklist – Surgery

LEFT SIDE: (top to bottom)	√ if present
Scheduling Form	
Demographic Information/Face Sheet	
Insurance Cards/Verification/Consent forms	
Promissory Note (if applicable)	
Assignment of Benefits	
Authorizations & Disclosures	
Advanced Directive	
Out-of-Network members	
Assignment of Anesthesia Benefits	
Pt. calculation/Driver's License/Office demo	

RIGHT SIDE: (top to bottom)	√ if present
Dictated Operative Report (Procedure Note)	
Pathology report (if applicable)	
Post procedure phone call	
Surgical Consent	
Anesthesia Consent	
H&P	
Doctors' orders	
Intraoperative record	
Anesthesia record	
Brief operative note (if applicable)	
Medical reconciliation sheet	
PACU record	
EKG sheet (if applicable)	
Discharge Instructions	
Preoperative record/phone call	
Surgical Checklist	
OR disposables	
Billing/Charge sheets	
Patient labels	

Surgeon	√ if present
Signed operative report	
Signed Surgical consent form	
Signed H&P	
Signed Doctor's orders (if applicable)	
Signed brief operative note (if applicable)	
Signed medical reconciliation sheet	
Other:	

Anesthesiologist	
Signed anesthesia consent form	
Completed/Signed anesthesia orders	
Signed anesthesia record	
Other:	

Pre-Op Nurse	
Signed completed Pre-Op record	
Signed surgical checklist	
Other:	

OR Nurse	
Signed intraoperative record	
Signed Pre-Op record	
Surgical Checklist sign-in	
Surgical Checklist sign-out	
Other:	

PACU Nurse	
Signed Doctor's orders	
Signed medical reconciliation sheet	
Completed/Signed PACU record	
Signed discharge instructions	
Other:	

Pathology/Culture Report (if applicable)	
Abnormal report - MD notified	
Via Fax	
Via Certified returned receipt mail	

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS, & DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, under any policy of insurance or other health care coverage in which the patient is a covered beneficiary, otherwise payable to me for services, treatments, therapies, including major medical, rendered or provided by the above-named health care provider, including their professional corporations or business entities, including without limitation, if applicable, pathology provider, anesthesia provider, and radiology provider by reason of this admission, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, including major medical, provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chosen action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Medicare: The undersigned parties do hereby assign, transfer and set over any and all Medicare benefits payable for health services relating to this admission to the above-named health care provider, including their professional corporations or business entities, including but not limited to, if applicable, pathology provider, anesthesia provider, and radiology provider, and hereby authorize said healthcare providers or their corporations to submit claims directly to Medicare for payment on behalf of the undersigned patient. Items not covered by Medicare will be the responsibility of the undersigned financially responsible party.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. **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 & FINANCIALLY RESPONSIBLE PARTY | RELATIONSHIP | DATE

_____ _____

WITNESS | DATE

PATIENT LABEL HERE

ADVANCED REGIONAL
Surgery Center, LLC

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 Advanced Regional Surgery Center. 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, Advanced Regional Surgery Center 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, [Surgery Center] 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 [Surgery Center], 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: Advanced Regional Surgery Center 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: Advanced Regional Surgery Center 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 Advanced Regional Surgery Center.

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 Advanced Regional Surgery Center will not perform my schedule procedure unless these arrangements are met, and have provided Advanced Regional Surgery Center with my designated responsible party's name and phone number. The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.

Responsible Party Name _____ Signature _____ Phone Number _____

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at Advanced Regional Surgery Center and I understand that the center policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact) is to initiate resuscitative measures, should an adverse

event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney.

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to Advanced Regional Surgery Center for any and all charges associated with the services rendered by Advanced Regional Surgery Center, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Advanced Regional Surgery Center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insurance carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all of the charges, Advanced Regional Surgery Center will pursue the internal appeals provided by the health plan, and will bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Advanced Regional Surgery Center may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.
2. Advanced Regional Surgery Center bills both patients and health plans using the same fee schedule, and my financial obligation is based on my applicable benefit levels associated with services for which Advanced Regional Surgery Center will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, patients and health plans are offered discounts, in accordance with the Advanced Regional Surgery Center Financial Policies, a copy of which is available to me upon request, and has also been made available to my health plan.
4. I am aware of my right to request a complete written estimate of the anticipated charges, and my associated financial responsibility. I understand that the fee quoted to me for the surgery facility is an ESTIMATE only, and it is possible that I will receive a bill for any balance which I remain financially obligated to pay.
5. 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.
6. When a payment is received by the patient, directly from the health plan they have assigned to Advanced Regional Surgery Center, patient must endorse and forward the payment and Explanation of Benefits to Advanced Regional Surgery Center as soon as the payment is received to avoid additional financial liability.

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 & FINANCIALLY RESPONSIBLE PARTY | RELATIONSHIP | DATE

_____ _____

WITNESS | DATE

ADVANCED REGIONAL
Surgery Center, LLC

ADVANCE DIRECTIVE and PATIENT RESPONSIBILITY ACKNOWLEDGEMENT

I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). If I desire to exercise this right, I understand that I must inform my physician of my wishes. I understand that if I have a Living Will, Durable Power of Attorney, and/or Advance Directive, I must inform Advanced Regional Surgery Center. I am aware that in the event of a life-threatening emergency, it is the policy of Advanced Regional Surgery Center, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, to initiate resuscitative or other stabilizing measures. If an adverse event should occur during treatment at this facility I will be transferred to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, Advance Directive, or Health Care Power of Attorney. My agreement with this facility's policy will not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

☐ I decline to implement an Advance Directive

☐ I would like to implement an Advance Directive and I have given Advanced Regional Surgery Center a copy of such directive.

☐ I have been given the opportunity to receive a copy of the Privacy Notice (HIPAA)

☐ I have been informed of my Patients' Rights and Responsibilities and a copy has been made available to me.

I understand that I may revoke this consent at any time by notifying Advanced Regional Surgery Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Advanced Regional Surgery Center took before receiving my revocation.

_____ _____

Signature of patient or patient's representative Date

_____

Printed Name of patient or patient's representative

_____ _____

Signature of witness Date

Pt label

ADVANCED REGIONAL
Surgery Center, LLC

360 Missouri Avenue 19A, Suite 102 / Jeffersonville, IN 47130 / 812-722-1480

Date: _____
To: Out of Network Members
Re: Non-Participating Provider Agreement
Patient: _____
Account: _____

It is the intention of Advanced Regional Surgery Center, LLC to extend ***"In-Network Benefits"*** to all of our patients. Your insurance company will pay Advanced Regional Surgery Center, LLC as a non-participating provider and it is our intention to honor their payment ***without additional cost to you*** than if we were a participating or "In-Network" provider.

It is possible that the insurance payment for your visit to Advanced Regional Surgery Center, LLC will be sent directly to you.

In the event that the payment is sent directly to you

- ***Please endorse the check over to the center and***
- ***Mail the check to the center in the self-addressed envelope that the center has provided.***
- ***Please include the Explanation of Benefits (EOB) that you will receive from your insurance provider***

By forwarding the payment, if received, from your insurance provider directly to the center, you avoid the possibility of additional costs for using the facility. Compliance with this request will allow the center to process the payment to your account quickly, efficiently and to make any necessary adjustments without the need to bill you for services due to non-payment. If you receive a payment directly from your insurance provider and do not forward it, the center will attempt to contact you to retrieve it so that your account can be closed.

_____

Patient/Responsible Party Date

_____

Witness Date

Pt Label

AUTHORIZATION FOR RELEASE OF INFORMATION

ASSIGNMENT OF ANESTHESIA BENEFITS

I hereby authorize EMA ANESTHESIA, P.S.C. to release medical information regarding my treatment to my insurance company.

I authorize payment of benefits for the anesthesia services to be made directly to EMA ANESTHESIA, P.S.C. I agree to pay my balance, promptly upon billing, should my insurance plan(s) not pay the claim within 90 days from service date. A 1 ½ percent service charge may be added to any account balance over 90 days old each month. A copy of this authorization will remain on file with EMA ANESTHESIA, PSC.

PATIENT STICKER

_____

Signature of Patient or Insured Person

_____

Date