COASTAL
SURGERY CENTER

Condition Of Admission

1. CONSENT TO MEDICAL TREATMENT

The undersigned consents to the procedures which may be performed, including emergency treatment or services, and which may include but are not limited to general care, laboratory procedures, x-ray examination, medical or surgical treatment/procedures and anesthesia. I understand the Coastal Surgery Center shall have the right at any time to refuse to admit me or provide medical care or treatment.

2. RELEASE OF INFORMATION

The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, Coastal Surgery Center may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of Coastal Surgery Center's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. The undersigned authorizes the release of medical records and/or information both to and from Coastal Surgery Center for the purpose of continued medical care and payment. The undersigned authorizes Coastal to act as a representative on his/her behalf to dispute payment or allowances which includes, but is not limited to, the pursuit of a claim, underpayment, or appeal of a denied claim from my insurance carrier.

3. FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligated himself/herself to pay the account of Coastal Surgery Center in accordance with regular rates and terms of the facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

If the undersigned is a Medicare patient, he/she knows that Medicare may deny payment. If Medicare denies payment, he/she agrees to be personally and fully responsible for payment.

4. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Coastal Surgery Center of any insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. It is understood by the undersigned that he/she is financially responsible for charges not covered by his/her insurance company under this agreement.

5. ARBITRATION

I hereby agree that any dispute between the patient and Coastal Surgery Center or its officers, directors, or employees, including, but not limited to any dispute as to medical malpractice, that is to whether any medical services rendered under this agreement were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court processes except as California law provides for judicial review of arbitration proceedings. Both parties to this agreement by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Such arbitration shall be in accordance with the current Medical Arbitration Rules of the California Hospital Association – California Medical Association. This arbitration agreement shall apply to any legal claim or civil action by patient against Coastal Surgery Center or its officers, directors, or employees in connection with any medical services rendered , unless patient or undersigned initials below or unless rescinded by written notice within 30 days of signature. An agreement to arbitrate shall not be a precondition to the rendering of services under this agreement.

If patient or myself does not agree to arbitrate then he/she will initial here: _____

I hereby certify that I have read the foregoing, received a copy thereof if requested, and am the patient, the patient's legal representative, or is duly authorized by the patient as the patient's agent to execute the above and accept its terms.

NOTICE:

BY SIGNING THIS AGREEMENT (BACK/SECOND PAGE) YOU ARE AGREEING TO HAVE ANY DISPUTE, INCLUDING ANY CLAIM OF MEDICAL MALPRACTICE, DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY/COURT TRIAL UNLESS YOU INITIALED #5 ABOVE.

6. LOST OR STOLEN PERSONAL ITEMS

Coastal Surgery Center is not responsible for any misplaced, broken, or stolen personal items on the Center's premises. All personal effects are the patient's responsibility.

Insurance Check Acknowledgement

Please read the following information regarding your financial responsibility for your surgical procedure at Coastal Surgery Center ("CSCSB") and acknowledge your understanding of this information by signing below.

- CSCSB will submit a claim to your insurance provider for the use of our facility during your procedure.
- Your insurance provider may send a check directly to you. Please understand that any check sent to you for services rendered by CSCSB should be endorsed by you to CSCSB and returned to our office immediately. If the check is not returned to the facility, it will be included in your balance due. Please note the check from your insurance provider is separate from your patient portion.
- Please keep in mind that CSCSB's fees are for your use of our Facility. You will receive separate bills from your Physician and Anesthesiologist.

Privacy Notice Acknowledgement

I have been offered and reviewed a copy of the Privacy Notice from the Surgeon's office and/or Coastal Surgery Center.

Identity Theft Regulation

In compliance with recent legislation regarding identity theft, our center is required to verify each patient's identity prior to service. Please bring in current photo identification (Driver's License, ID card, passport, etc) with you to your appointment. If you are a minor and do not have current photo identification, we can take a guardian or parent's identification in your place. If you do not have a current photo identification card for any other reason, you will need to bring someone with you to your appointment that can verify and attest to your identity and we will need a copy of their photo identification.

I have read the provided Condition of Admission, Insurance Check Acknowledgement and the Privacy Notice Acknowledgement information in a language I understand.

I have received information in a language I understand and been given an opportunity to ask questions about:

- **Advance Directives**
- **My Rights as a Patient**
- **My Rights and Protections Against Surprise Medical Bills**
- **My Physicians Part Ownership in this Ambulatory Surgery Center.**

I have read this packet of information prior to the date of surgery.

Patient Name (print) _____

Patient or Representative (signature): _____ Relationship: _____

Witness: _____ Date: _____ Time: _____ am/pm