Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # ______________________

Work # ______________________

Mobile # ______________________

Other ______________________

Place Patient Identification Label Here

E-Mail Communication Preferences

Email Address ____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that North Shore Surgical Suites, its legal agents, or affiliates may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, North Shore Surgical Suites, its legal agents, or affiliates may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update North Shore Surgical Suites when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? **(If no, please provide an alternate mailing address below.)**

____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information and/or financial information? (Check all that apply)

	Name:	**Telephone**
☐ Spouse	____________	____________
☐ Caretaker	____________	____________
☐ Child	____________	____________
☐ Parent	____________	____________
☐ Other	____________	____________

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

____________________________ ____________________________

Patient or Personal Representative Signature **Date**

____________________________ ____________________________

Printed Name **Relationship to Patient**

- Pursuant to Wisconsin State Legislature Chapter 153, the collection of race and ethnicity is a statutory requirement. Which means, we are REQUIRED as an Ambulatory Surgery Center to collect and report Race and Ethnicity to the state of Wisconsin through the Wisconsin Hospital Association on a quarterly basis.
- ***Please check the appropriate box that correlates to your Race and Ethnicity***: (Note: The Race and Ethnicity options and descriptions are set by the State of Wisconsin/Wisconsin Hospital Association and not our facility.)

RACE

☐	American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (Including Central America), and who maintains tribal affiliation or community attachment
☐	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.
☐	Black or African American	A person having origins in any of the black racial groups of Africa.
☐	Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
☐	White	A person having origins in any of the peoples of Europe, North Africa or the Middle East
☐	Declined	A person who refuses to answer this question
☐	Unavailable	A person unable to answer this question, or no available family member or caregiver to respond for the patient. May also be used by patients if their race is unknown

ETHNICITY

☐	Hispanic or Latino	A person of Mexican, Puerto Rican, Cuban, Central or South American, or Spanish culture or origin, regardless of race.
☐	Non-Hispanic or Latino	A person not of Hispanic or Latino ethnicity.
☐	Declined	A person who refuses to answer this question or cannot identify him/herself ethnicity
☐	Unavailable/Unknown	A person unable to answer the question, or ethnicity is unknown by the patient

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: I hereby authorize 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 North Shore Surgical Suites. 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 REIMBURSEMENT: For purpose of reimbursement, North Shore Surgical Suites 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.

AUTHORIZATION TO RELEASE MEDICAL AND PAYMENT INFORMATION TO SPECIFIC INDIVIDUALS: North Shore Surgical Suites and each attending or treating practitioner are hereby authorized and directed, during my period of this admission, to disclose medical and payment information to my spouse, children, parents, and any other person authorized to consent to treatment pursuant to current state law, concerning my health status, diagnosis, prognosis, and progress.

North Shore Surgical Suites is also hereby authorized and directed to disclose and discuss matters related to billing and payment after the period of admission. I do hereby release and hold North Shore Surgical Suites, 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.

I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care to whom medical and payment information may be released:

____

_______ Please do not release my medical or payment information to any individuals.

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 North Shore Surgical Suites will not perform my schedule procedure unless these arrangements are met, and have provided North Shore Surgical Suites 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 North Shore Surgical Suites 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. Please check one of the following:

- ○ YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record
- ○ YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me
- ○ NO, I do not have an Advanced Directive/Living Will/Health Care Proxy
- ○ I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to North Shore Surgical Suites for any and all charges associated with the services rendered by North Shore Surgical Suites, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. North Shore Surgical Suites 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, North Shore Surgical Suites will pursue the internal appeals provided by the health plan, and will only bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. North Shore Surgical Suites 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. North Shore Surgical Suites 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 North Shore Surgical Suites will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, patients and health plans are offered discounts based on the time of payment, in accordance with the North Shore Surgical Suites 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 North Shore Surgical Suites, patient must endorse and forward the payment and Explanation of Benefits to North Shore Surgical Suites as soon as the payment is received to avoid additional financial liability.

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

RELEASE OF RESPONSIBILITY FOR VALUABLES: North Shore Surgical Suites is hereby fully released of and from any and all responsibility for loss or damage to my personal property, money, or valuables.

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 is 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: North Shore Surgical Suites 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 North Shore Surgical Suites.

I have received a copy of the Patient Privacy Notice: _______ **I decline a copy of the Patient Privacy Notice: _________**

North Shore Surgical Suites Financial Policies

North Shore Surgical Suites 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. North Shore Surgical Suites 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.

**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.*

1. The surgery center bills both patients and health plans 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. 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.
9. 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.
10. 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.
11. Patients with no insurance coverage will be considered self-pay, and will be eligible for the 70% prompt pay discount off charges.
12. Written estimates of anticipated charges and associated financial responsibility are available upon request.
13. When patients receive payment directly from the health plan, patients must endorse and forward the payment and Explanation of Benefits to North Shore Surgical Suites 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. Detailed financial policies are available to the insurer upon request.