SOUTHWEST SURGICAL CENTER

2373 64th Street, Suite 2200
Byron Center, MI 49315

Patient Identification Label

REGISTRATION CONSENT

1. CONSENT TO MEDICAL CARE AND TREATMENT:
   While at the surgical center, I consent to all medical and surgical care, examinations and tests determined to be necessary for me. Though I expect the care given to meet customary standards, I understand that there are no guarantees concerning the result of my care. If I refuse treatment that is suggested for me, or if I leave the surgical center against medical advice, I will not hold the surgical center or any individual responsible for any of the consequences.

2. RELEASE OF INFORMATION:
   I authorize the Surgical Center to release any medical information, written, verbal, or faxed to bill my insurance company or their authorized representative, or [Worker's Compensation and to receive preadmission or continued length of stay certifications].

   I authorize the Surgical Center to release medical information to my family physician, referring physician, or agency(ies) needed to facilitate continuity of care. I authorize the Surgical Center to release medical information, written, verbal, faxed, or electronic to companies who provide billing services for physicians involved in my care.

   This authorization includes any information concerning diagnosis of alcoholism, drug abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or testing for Human Immunodeficiency Virus (HIV). This authorization shall remain valid for one (1) year.

3. ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
   I acknowledge that I have received or been offered a copy of Southwest Surgical Center's Notice of Privacy Practices and have had a chance to object to the use or disclosure of my information for directory, disaster relief, or to provide information to family or persons involved in my care.

4. ASSIGNMENT OF INSURANCE BENEFITS:
   I authorize payment of my insurance benefits directly to the surgical center. I understand that I am financially responsible for charges not covered by my insurance carrier.

5. STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS AND/OR COMMERCIAL INSURANCE BENEFITS TO PROVIDER AND PHYSICIAN:
   I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release this information to the Health Care carriers. I request that payment of authorized benefits be made on my behalf.

   I also assign the benefits payable for physician services to my physician(s) or his/her private practice organization, providing, however, that should my physician NOT ACCEPT THIS ASSIGNMENT AS PAYMENT IN FULL for his or her services, I understand I am responsible for full charges.

6. FINANCIAL AGREEMENT:
   As responsible party, I agree to pay the Surgical Center for all health care services provided to the patient within 30 days unless other arrangements are made. In the event my account is forwarded for collection activity, a one time 28% fee will be added to cover the additional cost to the facility. Should legal action be pursued, the venue for such action will be Kent County.

7. PERSONAL VALUABLES:
   I have read the patient brochure, which advised me not to bring personal valuables to the Southwest Surgical Center. I understand that the Surgical Center does not assume responsibility for any valuables I choose to bring with me the day of my surgery.

8. NON-COVERED SERVICES:
   I understand that services rendered to me may not be covered under Medicare, Medicaid, other insurances or payers. These services may include cosmetic surgery. These may also include services which your physician determined were medically necessary for you but which were later determined unnecessary by the paying agency.

9. SOCIAL SECURITY ADMINISTRATION RELEASE:
   I authorize the Social Security Administration to release to the Surgical Center information pertaining to my Medicare entitlement.

10. ACKNOWLEDGMENT OF MICHIGAN PUBLIC ACT 488, Section 333.5133, Subsection #12.
    I understand that as a patient of this facility I may be tested for the presence of Human Immunodeficiency Virus (HIV), and HIV antibody, and/or Hepatitis, without my consent, if a health care professional or employee is exposed to my blood or other bodily fluids. I understand that the expenses for such testing will not be my responsibility.

PLEASE REVIEW THIS DOCUMENT PRIOR TO CHECKING IN. YOU WILL BE ASKED TO SIGN A COPY OF THIS DOCUMENT UPON YOUR ARRIVAL TO THE SURGERY CENTER