Pacific Heights
SURGERY CENTER

Condition Of Admission

1. CONSENT TO MEDICAL TREATMENT

I hereby consent to the procedures which may be performed on the patient, 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. Pacific Heights Surgery Center shall not be liable for any loss or damage to money, valuables, personal property and/or clothing. I understand the Pacific Heights Surgery Center shall have the right at any time to refuse to admit or provide medical treatment to the patient. I certify that I am the patient, or the patient's representative authorized to execute this document and accept its terms.

2. RELEASE OF INFORMATION

I hereby agree that to the extent necessary to determine liability for payment and to obtain reimbursement, Pacific Heights 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 Pacific Heights Surgery Center's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. I hereby authorize the release of medical records and/or information both to and from Pacific Heights Surgery Center for the purpose of continued medical care, payment and reimbursement. I hereby authorize Pacific Heights to act as a representative on my 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. I agree that a photocopy of this agreement be as valid as the original.

3. FINANCIAL AGREEMENT

I hereby agree, regardless of whether I am the patient or the patient's representative, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the patient's account of Pacific Heights 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 I am a Medicare patient, I know that Medicare may deny payment. If Medicare denies payment, I agree to be personally and fully responsible for the full cost of payment for services rendered to me.

4. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize, regardless of whether I am the patient or the patient's representative, direct payment to Pacific Heights Surgery Center of any insurance benefits or reimbursements otherwise payable to or on behalf of the patient for the services rendered. I hereby understand that I am solely financially responsible for all charges not covered by the patient's insurance company under this agreement.

5. ARBITRATION

I hereby agree that 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 in connection with this outpatient service against Pacific Heights Surgery Center or its employees and by any doctor of medicine who has agreed, at the time of patient's admission as evidenced by written agreement in the physician's medical staff file to be bound by this provision, 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 PAGE) YOU ARE AGREEING TO HAVE ANY ISSUE 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

Pacific Heights Surgery Center shall not be held responsible for any misplaced, broken, or stolen personal items on the Center's premises. All personal effects are the patient's sole and exclusive responsibility.

Insurance Check Acknowledgement

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

- PHSC may submit a claim to your insurance provider for the use of our facility during your procedure.
- Your insurance provider may incorrectly send a check directly to you. This is out of our control and any such check is monies owed to the Center for services rendered to you. Please understand that any check sent to you for services rendered by PHSC should be endorsed by you to PHSC and returned to our office within two (2) business days of receipt by you. 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. Failure to comply with this section may subject you to civil and criminal liability.
- Please keep in mind that PHSC'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 have reviewed a copy of the Privacy Notice from the Surgeon's office and/or Pacific Heights Surgery Center of San Francisco.

Identity Theft Regulation

In compliance with 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 Condition of Admission, Insurance Check Acknowledgement and the Privacy Notice Acknowledgement information provided.

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 (including the Grievance Policy)**
- **My Physicians Part Ownership in this Ambulatory Surgery Center.**

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

Patient Name (print) _____

Patient or Representative (signature): _____ Relationship: _____

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