Metropolitan Surgical Institute, L.L.C.
540 Bordentown Avenue, Box-5
South Amboy, NJ 08876

PATIENT LABEL HERE

AUTHORIZATION TO RELEASE INFORMATION AND PAY FACILITY/ANESTHESIOLOGIST DIRECTLY

1. I authorize the Metropolitan Surgical Institute to release to appropriate third parties such information as may be necessary (including my Diagnosis)
2. I authorize all health insurance payments for services rendered to be sent directly to the Metropolitan Surgical Institute and/or the Anesthesiologist.
3. I understand that I am financially responsible to the Facility/Anesthesiologist for all charges not covered by insurance; This is a direct assignment of my insurance policy.
4. I acknowledge that the insurance information I have provided is accurate and true.
5. I understand that in the event of an emergency or the need for extended care, I may be transferred to a hospital. If I am transferred, I authorize the Metropolitan Surgical Institute to obtain a copy of my “Discharge Summary” so as to provide the Center with appropriate follow-up information.
6. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct and I authorize the Metropolitan Surgical Institute and/or the Anesthesiologist to release to the Medicare Bureau, CMS, and/or its intermediaries or carries any information about me needed for this claim including any medical information relating to my treatment.
7. I understand that I should not bring any valuables to the surgery center and that the surgery center is not liable for theft or loss of any valuables.
8. I understand that some of the Physicians who are rendering services have an ownership interest in the Metropolitan Surgical Institute and I have an option to be treated at another facility
9. I understand that I and/or my insurance company may receive more than one charge originating from different sources for this procedure. For example, separate fees may originate in addition to the physician’s fee and will be billed separately, (i.e., radiology, anesthesiology, facilities, laboratory fees).
10. A copy of the patient’s rights and responsibilities has been given to me or my representative.
11. I understand that with the exception of local anesthesia a patient representative must be present to drive me home from the Center after surgery and whose care I will be under for the next 24 hours.
12. I acknowledge the receipt of the HIPAA Notice of Privacy for patients for the Metropolitan Surgical Institute.

I have previously executed an Advance Directive (circle one) Yes No

IF YOU ANSWERED “YES”, READ THE FOLLOWING **IMPORTANT**

13. Some of the procedures and medications used during your surgery could be similar to procedures and medications specified in Advance Directives. Therefore to insure the best possible care during your surgery you MUST waive your Advance Directives during your surgical admission at the Center.
14. I acknowledge that all the resuscitative measures will be taken during my stay at the Center; And I further understand that if I have signed an “Advance Directive”, I temporarily waive it in its entirety for the duration of my visit at the surgery center.

By signing here, I agree to all 14 (Fourteen) authorizations on this page.

______________________________ ______________________

PATIENT SIGNATURE **DATE**

______________________________ ______________________

PARENT / GUARDIAN/ REPRESENTATIVE **RELATIONSHIP TO PATIENT**

(If Patient is unable or too young to sign)

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PRINT GUARDIAN / REPRESENTATIVE NAME

Where may a nurse contact you post- operatively?: Home______________________ Other________________________

If we’re unable to reach you where may we send a post-operative follow-up letter?;

Home:_______________________ Other ____