ADMISSION AGREEMENT

Consent for Admissions: I request and consent to admission to South Plains Surgery Center (SPSC).

Consent to Medical Care: I request and consent to medical care and diagnostic procedures that my attending physician(s) or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in SPSC is under the direction of my attending physician(s) and that the Center is not responsible for acts of omission of my attending physician(s). There are certain types of operations and procedures, such as direct abortion, which are not authorized at the surgery center and I agree to such policy as condition of admission.

Release of Information: I authorize SPSC to release any medical or financial information to a medical care provider who is performing medical care or a diagnostic test(s) on behalf of; or at the request of my attending physician, or his/her designees, of the Center. I authorize SPSC, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. **By state law,** you must be advised that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which includes, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Legal Guardian, Medical Durable Power of Attorney, Advance Directives:

Do you have a Legal Guardian? □ Yes □ No
If yes, please provide Name _____
Do you have a Medical Durable Power of Attorney? □ Yes □ No □ Copy on Chart
If yes, please provide Name _____
Do you have an Advance Directive? □ Yes □ No □ Copy on Chart

Privacy Practices, Patient Rights, Physician Ownership, Advance Directives and Patient Financial Responsibility Policies:

Have you received a copy of the SPSC Notice of Privacy Practices? □ Yes □ No

Have you received a copy of the SPSC Patient Rights and Responsibilities? □ Yes □ No

Have you received a copy of the SPSC Physician Ownership Statement? □ Yes □ No
Have you received a copy of the SPSC Advance Directives Policy? □ Yes □ No
Have you received a copy of the SPSC Patient Financial Responsibility Policy? □ Yes □ No

Personal Property: I have been informed and understand SPSC does not assume any responsibility for personal property that I choose to keep with me. I have been informed; however, that SPSC will keep my personal property in a designated location, upon request. I have been informed and understand that SPSC will not be liable for any loss of my personal property unless it is secured in a designated location maintained by SPSC.

Payment for Medical Care: I agree that, in consideration for the medical care I receive from the Center, its employees, agents, designees, or independent contractors, I guarantee full payment for all charges by SPSC or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third-party payor (for example, an insurance carrier or health maintenance organization (HMO) with which Center has specifically entered into an agreement for payment of medical care provided by the Center or by its employees, agents, designees or independent contractors.) In the event that SPSC has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to and services provided herein, I agree to pay the reasonable attorney's fees and collection expenses, including, without limitation, collection agency expenses, incurred by SPSC.

Assignment of Benefits: I hereby authorize and assign payment to SPSC, any type of reimbursement or payment from Medicare or State Medicaid programs or other third-party payor, for any and all cost of my medical care provided at the Center or by its agents, designees, or independent medical contractors. Further, I understand that **Anesthesiology, Physician Services, Pathology, Radiology** and some **Laboratory Services** may be billed to me separately and I assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim.

Insurance Precertification: I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Release of Financial Information: I hereby authorize SPSC, its employees, agents, designees, or independent contractor to disclose any and all information regarding the medical care I received on admission to this facility or through its employees, agents, and designees, or independent contractors to any third-party payor responsible for paying the costs of my medical care and any part thereof.

Agreement as to Governing Law and Forum: The patient or patient's representative and health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; (2) in the event of a dispute, any lawsuit, action or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

I have reviewed this Admission Agreement and fully understand its contents and implications.

_____

Signature of Patient, Parent, or Legal Guardian Date Please Print Name of Patient, Parent, Guardian

_____

Signature of Guarantor Date Please Print Name of Guarantor

_____

Employee Signature Date Please Print Name of SPSC Employee

If legal Guardian or Other Representative for the Patient, please provide your age and relationship to the patient, and the reason why the Patient Is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or are a parent or legal guardian of a child.