ADVANCED CENTER for SPECIAL SURGERY, LLC
6 Chestnut Ridge Road, Montvale, NJ 07645
Tel: 201-391-4700 Fax: 201-391-4701

Patient's Name: _____
Date of Birth: _____
Doctor's Name: _____
Date of Service: _____

Facility Consent Form

Consent for Treatment

I, the above-named and undersigned patient, give my consent for care at and by the medical, nursing allied professional staff of the above surgical center, which may include routine diagnostic procedures and such medical treatment as my doctor or his/her designees may find are needed. I acknowledge that no promises or guarantees have been made to me about the results of any examinations, treatments or procedures I may receive while at the Center.

Release of Medical Records

I authorize the Center to release all or any part of my medical record to (a) hospitals or medical service companies, insurance companies, workers' compensation carriers, welfare funds or other organizations or agencies that may be concerned with the payment of costs related to my treatment and (b) any other organization or agency to which the Center is permitted to release such information under applicable laws.

Financial Arrangements

I authorize and direct my insurer or payor to pay directly to the above Center any or all benefits, up to the amount of my bill, accruing to me in connection with my treatment. I agree that, in consideration of the services that were provided to me. I individually obligate myself to pay the account promptly in accordance with the regular rates and terms of the facility. I understand, therefore, that to the extent permitted under applicable laws and contractual arrangements, I am financially responsible to the Center for any amounts not covered by insurance. Furthermore, I understand that my insurer or payor may require certain health care services to be authorized before they are furnished to me. I individually obligate myself to pay the account of the Center with respect to services that I choose to receive notwithstanding that my health insurer or payor has refused to give preauthorization for all or any portion of my services.

Precertification: Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for physician and hospital services.

☐ **Out-of-Network**: I understand I am using my out-of-network benefits. This facility is not contracted with my insurance company to provide services. I understand that the reimbursement may be sent to me instead of the Center. Upon receipt of the insurance payment, I will forward the check and the explanation of benefits to the Center. In addition, I understand that my insurance plan may still hold me responsible for any deductibles and/or coinsurance. ☐ Payment made today ☐ No payment made today

*Note that failure to pay the applicable deductible and co-pay may affect your contractual obligations with your insurer, and thus your continuation of coverage. While Montvale Surgical Center may agree to await the explanation of benefits from your carrier to determine your responsibility for payment under your plan, payment is expected once determination of your responsibility under your plan is determined.

☐ **In-Network**: I understand I am using my in-network benefits. I understand that although the surgical center is contracted with the insurance company, my insurance plan may still hold me responsible for a deductible and/or coinsurance.

☐ **PIP/NO FAULT BENEFITS:** I understand I am using my PIP/No Fault benefits. In addition, I understand that my insurance plan may still hold me responsible for any deductibles and/or co-insurance.

☐ **WORKERS' COMPENSATION:** I understand I am using my workers' compensation benefits.

☐ **Self Pay**: I understand that my procedure is not covered by my insurance and that I am responsible for the entire fee.

Facility Charge: When your procedure is performed at the above surgical center, there will be a facility fee. There is a charge for the use of the surgical suite for your procedure. Fees will vary according to the type of procedure(s) that is/are being performed. Patient responsibility is dependent upon individual insurance plans.

Collection Expenses

Should my account with the surgery center be referred to an attorney or outside agency for collection, I will pay all reasonable collection expenses (including attorney's fees) associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

Patient Signature

The undersigned certifies that this form has been fully explained to him/her, and the undersigned is satisfied that he/she understands its content and significance.

Signature of Patient	Date	Time	Witness

Representative/Guardian Signature

Patient is a Minor or unable to sign because: _____

The undersigned certifies that this form has been fully explained, and the undersigned is satisfied that the contents are understood. The undersigned certifies that he/she has been duly authorized by the patient as the patient's legal representative or guardian to execute the above and accept on behalf of the patient.

Signature of Representative/Legal Guardian	Date	Time	Witness

 If you have any questions regarding the above information, please speak with the Administrator

Original on Medical Record / Copy to Patient

Additional Charges

Professional Fees: These are the fees that are billed by your physician for his services in performing your procedure. These fees are within the range considered usual and customary for this area. Patient responsibility will vary according to each insurance plan.

For questions pertaining to your physician's bill, please call: Your surgeon's office

Anesthesia: A board-certified anesthesiologist may be participating in your procedure in order to provide comfort and safety. This service would be billed to your insurance company.

For questions pertaining to your anesthesiology bill, please call: Advanced Ambulatory Anesthesia, LLC at 201-842-3941

Laboratory: Samples, possibly including blood or tissue biopsies, may be sent to a laboratory to be analyzed by a pathologist. You may receive a separate bill from the pathologist.

For questions pertaining to your pathology bill, please call:

☐ Rahway Pathology Associates at 732-499-6139
☐
☐ Other: _____

Radiology: You may receive a separate bill for any radiographic services related to your procedure.

For questions pertaining to your radiology bill, please call:

☐ NA
☐ Other: _____

Emergency Admission to Hospital or Emergency Room: You may receive a separate bill for hospital services should your health status require emergency transfer to a hospital.

Patient Rights / Notice of Privacy / Advance Directives

☐ Advance notice (prior to day of procedure), both verbally and written, was provided to me regarding patient rights and responsibilities, health information privacy, and advance directives.

☐ My referral to this center was made today due to medical necessity and I have been given verbal and written information regarding patient rights and responsibilities, health information privacy, and advance directives.

- ☐ I did not bring an advance directive.
- ☐ I have brought a copy of my advance directive to be placed on my medical record.

Acknowledgement of Driving Risks

I understand that the procedure I will receive today may cause conditions that render driving unsafe. I have been informed by the surgery center that I should not drive for at least 20 hours after receiving the procedure and that I should not attempt to drive until my symptoms have resolved. I understand that the Center will assist me in making alternative transportation arrangements if necessary and I so request. This does not apply to patients receiving local anesthetic (numbing medication).

Clothing and Valuables

I fully understand that the Center is NOT responsible for any personal property (clothing, eyeglasses, dentures, etc.) brought in or retained in the lockers at any time. I fully understand that any valuables (money, jewelry, and keys) should be given to a family member or other responsible party for safekeeping. I further agree to hold Montvale Surgical Center, LLC (MSC) harmless in the unlikely event of loss or damage of personal items during my stay at MSC.

Ownership Disclosure: I have been notified that my physician has a financial interest in this center (if applicable) and that I have a choice to go to another facility. ☐ Yes

Patient Signature

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Signature of Patient	Date	Time	Witness

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