MERCER COUNTY SURGERY CENTER

2A Princess Road, Lawrenceville, NJ 08648

http://mercercountysurgerycenter.com

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center and or physician's office is not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service.

CREDIT CARD ON FILE AGREEMENT

At Mercer County Surgery Center, we offer the ability to keep your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, the insurance portion of the claim has been paid and posted to the account and you are mailed a statement showing the remaining balance owed.

By my signature below, I authorize Mercer County Surgery Center to charge the portion of my bill that is my financial responsibility to the credit or debit card I provide to Mercer County Surgery Center for balances due for services rendered that my insurance company identifies as my financial responsibility. I understand that my card will be charged at any time after thirty (30) days since the date my last bill was mailed to me by Mercer County Surgery Center reflecting such balances. This authorization relates to all payments not covered by my insurance company for services provided to me by Mercer County Surgery Center. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a notification to Mercer County Surgery Center in writing and the account must be in good standing.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Mercer County Surgery Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service for charges not paid for within a reasonable period of time by insurance or third party payor. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Mercer County Surgery Center may have an ownership interest in the Center. Mercer County Surgery Center's physician owners are:

Dr. Armbruster, Dr Avhad, Dr. Cairone, Dr. Codjoe, Dr. Crivello, Dr. Dhillon, Dr. Eingorn, Dr. Hardeski, Dr Joseffer, Dr. Kleinbart, Dr Kothari, Dr McLaughlin, Dr. Nolan, Dr Shah, Dr. Simonian, Dr. Shivaprasad, Dr. Tormenti, Dr. Weinstein, Dr. Zak and Dr. Zambito. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Mercer County Surgery Center.

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that a copy of the Notice of Privacy Practices for Mercer County Surgery Center has been made available to me. I have the right to obtain a paper copy upon request. Version 1A

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

PATIENT RIGHTS/ADVANCE DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding Mercer County Surgery Center policies pertaining to ADVANCE DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

- **Do you have an ADVANCE DIRECTIVE? Yes_____ No_____**
  - **If "yes" did you bring it with you? Yes_____ No_____**
  - **If "no" you have the right to request one. Do you request one? [ ] yes [ ] no [ ] Given a copy** {00275169.DOC;1 }

PROCEDURE AND BILLING COMMUNICATION AUTHORIZATION

I hereby authorize the Mercer County Surgery Center and/or the physician performing my procedure to communicate information regarding my procedure/results of my procedure/billing to/with:

- **My spouse/family member/other Name(s): _____ _____Initials**
  - **Relationship: _____**
- **Leave a message on my voicemail/ answering machine: Yes_____ No_____ _____Initials**