

CONSENT TO AMBULATORY SURGICAL CARE: I am requesting ambulatory surgical care and wish to be treated at the Andrews Institute ASC, LLC. I hereby voluntarily consent to receive all such medical treatment and facility services while I am a patient that my physician and all persons caring for me consider to be necessary to me. I understand that this care may include diagnostic tests, examinations, medical and surgical treatment and related services. A list of usual and customary charges is available upon request. I am aware that the practice of medicine and surgery is not an exact science, and I hereby acknowledge that no guarantees have been made to me to the results of treatments or examinations in this facility. I understand that advanced directives will not be honored at the Andrews Institute ASC, LLC.

ASSIGNMENT OF INSURANCE BENEFITS: In consideration of services received or to be received for this admission, I assign to Andrews Institute ASC, LLC all benefits herein specified. I further warrant that such benefits are or will be justly owed to me, that no part of the same has been assigned or encumbered by me and that said facility shall be entitled to the full amount of its charges from same without setoff. This assignment shall be irrevocable.

GUARANTEE OF ACCOUNT: In consideration of services rendered or to be received (for this date) I hereby agree to pay any and all facility charges that exceed or are not covered by my medical insurance coverage or any other third party payer, and waive any and all notice and demand in the event of non-payment there under.

WAIVER OF LIABILITY FOR NON-APPROVED SERVICES, HMO MEMBER AGREEMENT: If your HMO or Insurance Company did not give you prior approval for medical/surgical services, and you choose to have services provided, you will be required to pay for the service. My signature acknowledges I have read and understand the above. If my insurance company denies payment, I agree to be personally and fully responsible for payment.

RELEASE OF INFORMATION: I authorize Andrews Institute ASC, LLC to use and disclose confidential medical information about me for treatment payment and health care operations. This includes information about substance abuse, mental health services or HIV, if applicable. I consent to the release of medical information about me to any insurer, third party, the Social Security Administration, or any agents or consultants Andrews Institute ASC, LLC reasonably uses to get payment for my treatment and for other health care operations.

PERSONAL VALUABLES: I understand that Andrews Institute ASC, LLC does not assume responsibility for any articles of clothing, money, jewelry, or personal items kept in my locker or on my person.

ACKNOWLEDGEMENT OF RECEIPT: My signature only acknowledges my receipt of this Message from Medicare, my Medicare HMO and does not waive any of my rights to request a review or make me liable for any payment. Andrews Institute ASC, LLC is pleased to be associated with the physicians who have chosen this facility to engage in their private practice of medicine. Physicians who render professional services to you at the Andrews Institute ASC, LLC may have an ownership of interest in the Andrews Institute ASC, LLC. It is your option to be treated in another facility. Physicians who render professional services to you at the Andrews Institute ASC, LLC are independent practitioners and are not employees or agents of Andrews Institute ASC, LLC. The Andrews Institute ASC, LLC is not responsible for the acts of omissions of physicians that are not directly controlled by Andrews Institute ASC, LLC.

Signature of Patient or Legal Representative

Date

ASC Staff Witness

Date

Patient Label