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

ANDREWS INSTITUTE
AMBULATORY SURGERY CENTER

Paradigm Anesthesia. P.A.
1040 Gulf Breeze Parkway
Gulf Breeze, FL 32561

An anesthesiologist is a doctor whose medical specialty involves the administration of anesthetic agents before, during and after surgery. In other words, an anesthesiologist is the person who puts you to sleep before and wakes you up after the surgery.

Like other physicians, an anesthesiologist's professional services are billed and paid separately from the facility.

If you have insurance, Paradigm Anesthesia will bill your insurance company for you. If your insurance company pays part or none of our charges, you will be billed for any remaining balance, if you do not have insurance, Paradigm Anesthesia will send a bill to you directly.

I hereby authorize my insurance carrier to make payments for my anesthesia services directly to Paradigm Anesthesia, P.A. I also authorize Paradigm Anesthesia, P.A. to provide my insurance carrier with any information needed to process my anesthesia claims. Furthermore, I understand that I am responsible for the payment of any balance remaining after insurance makes payment. In the event that my accounts are referred to an attorney for collection, the undersigned agrees to pay all costs of collection, including a reasonable attorney's fee.

YOU WILL RECEIVE A SEPARATE BILL FROM
PARADIGM ANESTHESIA
THIS IS NOT INCLUDED IN YOUR ANDREWS ASC BILL.

Patient/Guardian's Signature:_____ Date_____

ASC Staff Witness: _____ Date_____

Patient Label

ADVANCE DIRECTIVES / DO NOT RESUSCITATE CONSENT FORM

POLICY: Patients' who have a Living Will with Advance Directives or a DNR order will be evaluated by their Surgeon and/or Anesthesiologist before having a procedure at the Andrews Institute ASC. Andrews Institute Ambulatory Surgery Center will always attempt to resuscitate a patient and transfer that patient to the hospital in the event of deterioration. The hospital will be advised of the patients Advance Directive/Living Will status.

☐ **I DO NOT have a Living Will with Advance Directives, a Do Not Resuscitate (DNR) order, or a Durable Power of Attorney for Health Care.**

- ☐ **I would like an information packet regarding Advance Directives and other Health Care Decisions.**
- ☐ **I do not want any information about Advance Directives.**

☐ **I DO have a Living Will with Advance Directives, a Do Not Resuscitate (DNR) order, a Durable Power of Attorney for Health Care.**

- ☐ **I have brought a copy of my Advance Directive to be placed in my file.**
- ☐ **It is on file at:** _____

_____ **My surgeon or anesthesiologist has discussed this policy with me and has answered all my questions.**

_____ **I agree to have my procedure performed at the Andrews Institute ASC and understand that, if necessary, measures will be initiated to resuscitate me while I am a patient at the Andrews Institute ASC.**

_____ _____
Signature Date

Relationship to Patient: _____

_____ _____
(If Patient had Living Will Only) Date
Nurse Signature – Discussed with Patient

May 2013

Patient Label

ANDREWS INSTITUTE
AMBULATORY SURGERY CENTER

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that a staff member of Andrews ASC, LLC has offered me a copy of their Privacy Notice.

_____ _____

Patient or Legal Representative Date

_____ _____

ASC Staff Witness Date

Rev. 10/30/13

Patient Label