Lake City Surgery Center Disclosure/Authorization Form

SECTION A: NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

Lake City Surgery Center is owned by a corporation including local physicians, one of whom may be your physician. These physicians have become Owners as a result of their patients, under current Florida law, a physician-owned facility may not provide item or services to patients unless the patient signs a written notice disclosing certain matters. Please be advised of the following: Lake City surgery Center (may have financial relationship with your physician as indicated above). A schedule of typical fees for services provided by the facility is available at your request. You have the right to choose where you receive services; including an entity in which your physician may have a financial relationship. Two responsible sources of services available are: Lake City Medical Center, 1701 U.S. 90 West, Lake City, Florida 32055, (386) 7522922 and Lake Shore Hospital, 560 Franklin Street, Lake City, Florida 32055. By providing these names, Lake City Surgery Center is merely complying with legal requirements. By my signing below, I am Acknowledging my receipt of a copy of this notice of Ownership Interest on the date set forth below.

Patient/Patient's Legal representative____ Witness____

SECTION B: TREATMENT AUTHORIZATION, ASSIGNMENT OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT

I. **AUTHORIZATION FOR ROUTINE DIAGNOSTIC PROEDURE AND MEDICAL TREATMENT –** I hereby consent to such diagnostic procedures, out-patient care, medical treatment and the taking of photographs or video tape that do not reveal my identity, which in the Judgment of my physician may be considered necessary or advisable while a patient at Lake City Surgery Center. Lake City, Florida. I consent to the use of all my medical data and any non-identifiable photographs or video tapes for educational and research purposes at the discretion of my physician.

II. **SOCIAL SECURITY MEDICARE (IF APPLICABLE) -** I the undersigned, certify that the information given by me is applying under "Title XVIII of the Social Security Act is correct. I authorize Lake City Surgery Center and my physicians to release to the Social Security Administration or its intermediaries any information needed for processing of this or any other related Medicare claim. I request and assign that payment of all authorized benefits be made to the Lake City Surgery Center and/or physicians on my behalf. I assign payment for the unpaid charges for certain physician services furnished by specialists, and by physicians for whom the hospital/surgery center is authorized to bill. I understand that I am personally responsible for any non-covered services, health insurance deductibles and coinsurance.

III. **MEDCIAID (IF APPLICABLE) –** I, the undersigned, certify that I am a recipient of the Medicaid Program, Title XIX, and request that payment of authorized benefits by made on my behalf to Lake City Surgery Center or its assigned. I authorize Lake City Surgery Center and my Insurance Carrier to make available to the Division of Family Services in my state any requested information concerning medical insurance and financial records relating to outpatient care. I hereby certify all insurance pertaining to outpatient care and treatment, is here by assigned to the Lake City Surgery Center and/or physicians for services provided.

IV. **COMMERCIAL INSURANCE AND ASSIGNMENT –** By signing in the space below as Patient and/or Subscriber, I hereby authorize, request, and assign payment directly to those organizations who render bills covering this period of treatment, and past and future treatment if related to the incident or condition giving rise to this admission, by all insurance carriers with whom I have coverage or from whom benefits are, or may become payable to me including settlements or judgments flowing from the incident fro which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me, but shall not exceed the regular charges for this and my other period of treatment.

V. **RELEASE OF MEDIAL INFORMATION (INSURANCE COMPANIES, GUARANTOR, PHYSICIANS)**- By signing in the space below as Patient/Guardian,/Representative, I hereby authorize Lake City Surgery Center and Physicians to release information and/or copies of my medial record to the Hospital, Physicians, Guarantor on my accounts of Insurance companies for which I have assigned benefits for my treatment and care, and if requested, to my referring physician or any other healthcare facility responsible for my care. This includes: authorization to release information pertaining to psychiatric and/or psychological care, alcohol and/or substance abuse, AIDS, ARC, or HIV diagnosis testing and/or treatment for this period of illness, and other admission if related to the accident or illness giving rise to this admission, medical and other information as may be required to secure payment for charges incurred by me or in my behalf including a diagnosis of my condition.

VI. **INPATIENT VALUABLE RELEASE-** By signing in the space below as Patient/Guardian/Representative, I acknowledge that I have been given an opportunity to deposit valuables and money for safekeeping. I understand that Lake City Surgery Center assumes no responsibility for personal items or valuable retained by the patient.

VII. **GUARANTOR AGREEMENT**- By signing in the space below as Patient/Guardian/Representative or Guarantor or as Patient's/Guardian's/Representative's Spouse, I hereby agree that all changes connected with this treatment, and past and future treatment if related to the incident or condition giving rise to this admission, not covered by any insurance, program, sponsorship or other third party coverage I may have are due and payable by me a the time of discharge or discontinuation of treatment. **The charges I agree to pay are those listed in the current bulling charge manuals which are available for inspection upon request and incorporated herein by reference.** I hereby acknowledge that if Lake City Surgery Center has agreed to bill my Insurance or other third party carrier it has agreed to do so as a courtesy and that Lake city Surgery Center has the right, should Lake City Surgery Center deem it advisable to demand payment if full from me at any time prior to full payment from any insurance carrier unless Lake City Surgery Center and my Insurance company or third party carrier have agreed that I will not be billed I hereby acknowledge having been told that I may be billed by Lake City Surgery Center and any of the following: Physicians Business Network, Anesthesia Care, or Contracted Pathology Services and that each account for services rendered is a separate account and that an itemized bill is available upon request. I further agree that if I am more than thirty (30) days delinquent in the payment f any bill connected with this treatment, and past and future treatment if related to the incident or condition giving rise to this admission, interest on the amount due will accrue at the maximum amount allowed by law, and if the delinquent account is referred to collections, I agree to pay the attorney's fees, court costs and/or collections agency fees associated with the collection process.

Patient/Legal Guardian/Legal Represntative____

Subscriber____

Guarantor____ Guarantors Spouse____________________________________

(If other than Patient/Legal Guardia/Legal Representative) **(If other than Patient/Legal Guardia/Legal Representative Spouse)**

Witness____ Date______________________________