thesurgicalsuites
1100 Ward Avenue, Suite 1001/1010 Honolulu, HI 96814 Patient Name _____ Date of Birth _____

AUTHORIZATION FOR ADMISSION AND TREATMENT

Non-Discrimination Policy: The Surgical Suites (TSS) will admit and treat patients regardless of race, color, national origin, sex, sexual orientation, marital status, veteran's status, age, and/or disability.

Consent to Treatment: I authorize and consent to medical care and treatment at TSS (including diagnostic test and procedures) which my treating physicians and medical providers find to be necessary and which is given or performed at their direction.

Patient Rights & Responsibilities: My signature below will confirm that I have been given a copy of the "Patient Rights and Responsibilities." I have been informed that my physician has a financial interest in TSS.

Valuables Policy: Patients are discouraged from bringing their valuables and personal property into TSS. If I am unable to send valuables home, TSS will provide a locker and I agree that the total liability for loss or damage to such property stored is limited to $500 per patient. I agree that TSS will not be responsible for any loss and damage to such property kept in my possession.

Financial Agreement: I understand that I am responsible for paying my TSS bill in full within 90 days (or longer if required by law) unless I make other arrangements with the TSS Financial Department prior to surgery. I also agree to these additional terms.

Late Payment Charges: A late payment charge of 1% per month, calculated at simple interest, will be assessed on all accounts not paid in full within 90days (or longer if required by law).

Collection: If the bill is not paid in full within 90 days (or longer if required by law), I understand that TSS may refer the matter to an attorney and/or collection agency and that I will be responsible for paying all legal fees and other costs incurred to collect my bill.

If I Have CHAMPUS Coverage: I request payment to TSS of authorize benefits for all services furnished me by TSS. I authorized any holder of medical or other information about me to release to CHAMPUS and its agents by information needed to determine these benefits or benefits for relate services.

If I have Medicare Coverage: I certify that the information given by me applying for payment under Medicare is correct. I authorize the Social Security Administration to release information on my Medicare effective dates and Medicare claim number to TSS. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare claim. I request that payment of benefits be made to TSS on my behalf.

Assignment of Insurance Benefits and Payment: I understand that I am responsible for paying my bill in full. If I am entitled to any insurance benefits, I assign all of these benefits to TSS toward payment of my bill and direct my insurance carrier to pay these to TSS. TSS will bill my insurance carrier if I provide the appropriate information in a timely fashion.

Separate Professional Billing: The physicians and others providing medical services to me at TSS may be independent contractors who are not employees or agents of TSS, including Diagnostic Laboratory Services, my private surgeon(s) and anesthesiologist, Pathology Associates, Aloha Lab, and others. These independent medical providers will bill me separately for their services and I agree to make separate arrangements for paying them.

RELEASE OF INFORMATION

I understand that, except as provided in the "Notice of Confidentiality Practices," which I have read and signed, my health information of this admission and/or course of treatment may be disclosed for the purpose of treatment, for obtaining payment for my insurers and other payers and for the qualified health care operations, within the limits of the law.

I further understand that certain specific categories of my health information require my consent before release. If my medical records for this admission and/or course of treatment contain any information related to sexually transmitted diseases, Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnosis and treatment , and/or my use/abuse of drugs, alcohol or other substances, I consent to release such health information for the purpose of treatment for obtaining payment from my insurers and other payers qualified health care operation, within the limits of the law. I understand that I may revoke this authorization by informing the TSS Medical Records Department in writing and that this authorization is valid unless and until I revoke it in writing.

I certify that I have read this Authorization and that I am the patient, or the patient's authorized representative. On my behalf (and behalf of the patient) I accept and agree to be bound by the Authorization, a copy of which will be made available upon request.

X _____ **Date:** _____ **Time:** _____ **:** _____ **a.m. / p.m.**
Signature of Patient

X _____ **Date:** _____ **Time:** _____ **:** _____ **a.m. / p.m.**
Signature of Patient's Representative

X _____
Relationship to Patient

X _____
The Surgical Suites Representative