Parkway Surgery Center Financial Agreement

Patient name **Date of Service** **Account# (for facility only)**

DOB_____ **Age**____ **Sex**____ **MS** **Home Phone:**_____

Address: _____ **Email:** _____

_____ **Cell Phone:** _____

GUARANTOR _____ **Work Phone:** _____

Address: _____ **Employer:** _____

INSURANCE #1 _____ **Policy #** _____ **AUTHORIZATION#:** _____

Group # _____

_____ **Subscriber:** _____ Insured SS#:_____

_____ **Rel to Pt:** _____ Insured DOB:_____

_____ **Group Name** _____

INSURANCE #2 _____ **Policy #** _____ **AUTHORIZATION#**_____

Group # _____ **Insured SS #:**_____

_____ **Subscriber:** _____ **Rel to Pt:** _____

_____ **Group Name** _____ **Insured DOB:**_____

I hereby authorize any benefits due me under this policy to be paid in accordance with this assignment in consideration of hospital, medical and/or anesthesiology services rendered me or my dependent. I hereby assign and transfer any benefits due me under the above-described contract as follows, insofar as they are necessary to cover the expense:

FINANCIAL AGREEMENT

1. In the consideration of the services to be rendered to me. I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF Parkway Surgery Center, LLC IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF THE CENTER. Should the account be referred to an attorney or licensed collection agency for collection, I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within 60 days of service) shall bear interest at a legal rate.
2. I hereby authorize direct payment to The Surgery Center of any insurance benefits otherwise payable to me for this admission at the rate not to exceed The Surgery Center's regular charges. It is agreed that payment to The Surgery Center, pursuant to this authorization, by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand I am financially responsible for charges not covered by this assignment.
3. If I have been quoted a patient financial responsibility, I understand that it is subject to change if more procedures are performed than originally scheduled, a different procedure or extraordinary supplies are used that were not apart of my original estimate.
    a. I understand Parkway Surgery Center, LLC has the right, at any time, to refuse to admit me or to provide medical care or treatment for me.
    b. I certify I am the patient or I am duly authorized by the patient as said patient's general agent to execute this document and accept its terms.
4. I understand that, as a courtesy, Parkway Surgery Center, LLC will file my insurance. The total balance is considered due and payable 60 days from the date of surgery. I acknowledge that I have received a copy of center's "Notice of Privacy Practices."

X _____ _____

Signature of Patient (or other legally authorized representative) Date

X _____ _____

Witness (performed by member of facility, do not sign) Date

Parkway Surgery Center

100 N Green Valley Pkwy Suite 125, Henderson, NV * (702)-616-4954
10561 Jeffreys St Suite 130, Henderson, NV * (702)-724-8900

Advanced Directives

All patients have the right to participate in their own healthcare decisions and to make Advanced Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. Parkway Surgery Center respects and upholds those rights. However, unlike in an acute care hospital setting, Parkway Surgery Center does not routinely perform "high risk" procedures. While no surgery is without risk, most surgeries performed at this center are considered to be at minimal risk.

You will discuss the specifics of your procedure with your physician who can answer your questions regarding its risks, your expected recovery, and care after your surgery. Our team is dedicated to delivering the highest quality care in a safe environment that places the patient at the center of our care.

It is the policy of Parkway Surgery Center that if an adverse event occurs during your procedure or treatment, the medical surgical team will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. We will share your Advanced Directive with the caregivers at the acute care hospital where you are transferred. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.

If you do not agree with our facility policy we will assist you to reschedule your procedure in a facility more suited to meet your healthcare needs.

INT_____I have Advance Directives, Living Will or Healthcare Power of Attorney. If yes, did we receive a copy? (Circle One) Yes / No

INT_____No, I do not have Advance Directives, Living Will or Healthcare Power of Attorney

INT_____I would like to have information on Advance Directives

Injury Information

Was injury due to accident (circle one)? Yes No

Work related (circle one)? Yes No If yes, workman's comp carrier/phone number? _____

Patient Rights and Responsibilities

I have received a copy of my patient rights and responsibilities and have had the opportunity to ask any questions regarding them (located on the website)

Ownership Disclosure

Parkway Surgery Center is proud to have a number of quality physicians invested in our facility. Their investment enables them to have a voice in the administration of our facility. This involvement helps to ensure the highest quality of surgical care for our patients! Please be advised that your physician may or may not have an investment interest in this facility.

My physician has an investment interest in the surgery center (performed by member of the facility): Yes / No

Transportation after the procedure

If you are having sedation, you MUST have a responsible adult (18 or older) available to take you home after your procedure.

NAME OF PERSON DRIVING: _____ PHONE NUMBER: _____

By signing this document, I acknowledge that I have received and understand the written and verbal information provided to me regarding the statements above.

Patient Signature: _____ Date: _____

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # _____ Work # _____

Mobile # _____ Other **#** _____

E-Mail Communication Preferences

Email Address _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Parkway Surgery Center or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/ artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, Parkway Surgery Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

I recognize that text messaging is not a completely secure means of communication because these messages can be accessed improperly while in storage or intercepted during transmission. The text messages you receive may contain your personal information. If you would like us to contact you by text message please sign this consent below. If you consent to receiving text messages you also agree to promptly update Parkway Surgery Center when your mobile phone number changes. You are not required to authorize the use of text messaging and a decision not to sign this portion of the authorization will not affect your health care in any way.

_____

Patient's Signature for consent to text message.

Mail Communication Preferences

May we send mail to your home address? (If no, please provide an alternate mailing address below.)

_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

		Name:	**Telephone**
☐	Spouse	_____	_____
☐	Caretaker	_____	_____
☐	Child	_____	_____
☐	Parent	_____	_____
☐	Other	_____	_____

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____
Patient or Personal Representative Signature **Date**

_____ _____
Printed Name **Relationship to Patient**

FOR INTERNAL USE ONLY

Name of Employee_____ Signature of Employee_____

If applicable, reason patient's written acknowledgement could not be obtained:

☐ Patient was unable to sign.
☐ Patient refused to sign.
☐ Other _____
_____

_____ - _____ (Version: As noted on NPP) _____(Date: As noted on NPP)

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT
Parkway Surgery Center, 100 N. Green Valley Parkway, Suite 125
Henderson, Nevada 89074 | Phone (702) 616-4954 Fax (702) 269-0436

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Henderson, Nevada 89052 | Phone (702) 724-8900 Fax (702) 892-8854