774 Christiana Road
Suite 2
Newark, Delaware 19713

Phone: (302) 738-0300
Fax: (302) 355-0155

DOCS DELAWARE OUTPATIENT CENTER FOR SURGERY

SURGERY CENTER ADMISSION

LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIANS: I understand that all physicians furnishing services to the patient, including the patient's physician, and any specialist such as an anesthesiologist, radiologist, or pathologist are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under the care and supervision of his/her physician and it is the responsibility of the surgery center and its staff to carry out instructions of the physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, when required, to medical or surgical treatment or procedures. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's physician.

OTHER PROFESSIONAL SERVICES: I understand that my physician may have a professional radiology service review radiological images. My physician may also send specimens to a professional pathology laboratory for a pathological diagnosis. Radiology and pathology services are billed separately by those individual physicians and laboratories.

PERSONAL VALUABLES: It is agreed and understood that the surgery center shall not be responsible for any personal property brought by patient to the surgery center, including but not limited to money, jewelry, documents, or any other articles.

OWNERSHIP OF SURGERY CENTER: I understand that my physician may be an owner of this surgery center. I understand that I am free to choose another facility in which to receive the services that have been ordered by my physician.

ADVANCE DIRECTIVE/LIVING WILL: I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, the surgery center will still transfer me to the closest hospital which will make decisions about following any advance directive or living will.

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges (including but not limited to insurance companies, health care service plans, or worker's compensation carriers). Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-payments owed at the time of services. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorneys' fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law. I hereby certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any other payer is correct. I assign to the Surgery Center, all benefits due me under the terms of said policies and programs but not to exceed the Center's regular charges for similar services. **I authorize payment of medical benefits to the surgery center for the services provided.**

PATIENT PRIVACY, RIGHTS AND RESPONSIBILITIES: I have received a copy of the Privacy Notice and the Patient Rights and Responsibilities. I know to whom I can express suggestions or complaints.

I hereby acknowledge the above statements.

_____   _____
Patient   Date   Witness   Date

(In the event the patient is a minor, unconscious, or is otherwise not competent to acknowledge an understanding due to physical or mental condition, complete the following.)

If patient's personal representative, state relationship and authority:

_____   _____
Patient's personal representative   Date   Witness   Date