RIVERVIEW Surgery Center, LLC

Patient Registration Form

Please print. *All information is strictly confidential.*

MRN _____ PATIENT NAME _____

ADDRESS _____

HOME PHONE (_____)_____ WORK PHONE (_____) _____ EXT. _____

CELL PHONE (_____)_____ OTHER (_____)_____

GENDER: MALE FEMALE BIRTHDATE _____ / _____ / _____ SSN _____

PRIMARY CARE PHYSICIAN_____ DRIVER'S LICENSE # _____

RESPONSIBLE PARTY INFORMATION *Complete if patient is not responsible party or if patient is a minor.*

RESPONSIBLE PARTY_____ SSN _____

ADDRESS_____

INSURANCE INFORMATION *Please complete below, AND give office your card to copy.*

PRIMARY INSURANCE _____ ID # _____

GROUP # _____ POLICY HOLDER _____ DOB_____

RELATIONSHIP TO PATIENT _____ CLAIMS ADDRESS _____
_____

EMPLOYER _____ EMP STATUS: FT PT STUDENT RETIRED OR NOT EMPLOYED

SECONDARY INSURANCE_____ ID # _____

GROUP # _____ POLICY HOLDER _____

DOB_____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EMP STATUS: FT PT STUDENT RETIRED OR NOT EMPLOYED

EMERGENCY CONTACT

PERSON TO NOTIFY IN CASE OF EMERGENCY #1 _____

RELATIONSHIP _____ PRIMARY PHONE #: (_____)_____, HOME / MOBILE / WORK

SECONDARY PHONE #: (_____)_____, HOME / MOBILE / WORK

Only if this is your second visit please complete the following:

I have reviewed and confirm that the information provided is correct.

REVIEWED & AFFIRMED, NO CHANGES _____ _____
Signature Date

SIGNATURE: _____ RELATIONSHIP TO PATIENT: SELF / _____

PRINT NAME (if other than patient) _____ DATE _____

RIVERVIEW
Surgery Center, LLC

NPO

I _____ , acknowledge that I have not had anything to eat or drink (Including candy, gum,
Print Name

water etc.) since, _____ , at _____ .
Date Time

OWNERSHIP DISCLOSURE

I, (Patient Name)_____ , am aware

Dr. _____has or may have an ownership interest in the RIVERVIEW SURGERY CENTER, LLC. I understand that I may chose any other outpatient facility for the purpose of having the surgery performed. I have decided to have my surgery at RIVERVIEW SURGERY CENTER, LLC.

Advance Directives / Living Will / Health Care Proxy

I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). I also understand that my directives will be **suspended** while undergoing procedures at Riverview Surgery Center, LLC.

☐ Yes, I have an Advance Directive / Living Will / Health Care Proxy but did not bring it with me.
☐ No, I do not have an Advance Directive / Living Will / Health care Proxy.
☐ I wish to have information on how I can obtain an Advance Directive / Living Will / Health Care Proxy.

ACKNOWLEDGEMENT OF RECEIPT

☐ Patient Rights and Responsibilities
☐ Policy on Advance Directives
☐ Disclosure of Ownership
Your physician ☐ Does ☐ Does Not have a financial interest in this facility

TRANSPORTATION RELEASE

I understand that the anesthetic to be administered to me may have effects that may make it hazardous for me to drive a car or to otherwise travel alone to my home following the recovery period. I do understand that Riverview Surgery Center, LLC will not perform my scheduled surgical procedure unless I have arranged a responsible person to accompany me and transport me to my home.

I have been advised to have someone with me at home the evening of my surgery. I also understand that I will not be discharged until the responsible person transporting me home has signed this form prior to the discharge.

I hereby assume responsibility for accompanying and transporting the above-named patient to his/her home.

Signed: _____
Responsible Person Phone Number

Signed: _____
Patient Date

RIVERVIEW
Surgery Center, LLC

Acknowledgement of Privacy Notice Receipt

I have been provided a copy of the Notice of Privacy Practices for Riverview Surgery Center, LLC with an effective date of June 2012.

_____	_____
Signature of patient or patient's representative	Date
_____	_____
Printed name of patient or patient's representative	If applicable, relationship to patient

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining

Emergency situation prevented obtaining

Other:_____

Staff signature:_____

Witness signature:_____

RIVERVIEW
Surgery Center, LLC

AUTHORIZATIONS & DISCLOSURES:

These AUTHORIZATIONS MUST BE SIGNED BY THE PATIENT (or by the party legally responsible for a minor or physically or mentally incapacitated patient), and by the party financially responsible for the patient, if other than the patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

1. **AUTHORIZATION FOR MEDICAL TREATMENT:** Each of the undersigned hereby authorize any anesthesia, medical or surgical treatment, and Riverview Surgery Center, LLC service rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated for purposes and diagnosis, treatment and medical care. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OF SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.
2. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:**
    a) For Purpose of reimbursement: Riverview Surgery Center, LLC and each attending or treating practitioner, including, if applicable, PATHOLOGY, ANESTHESIA, and/or RADIOLOGIST, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, to my insurance companies, and other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. WE UNDERSTAND THAT SUCH DISCLOSURES MAY CONTAIN INFORMATION WHICH COULD RESULT IN LIMITATION OR DENIAL OF INSURANCE BENEFITS OR THIRD PARTY REIMBURSEMENT OR WHICH COULD OTHERWISE BE HARMFUL OR PREJUDICIAL TO MY (OUR) INTERESTS. Nevertheless, each of the undersigned do hereby release and hold Riverview Surgery Center, LLC, its officers, directors, agents and employees, and all examining and treating practitioners harmless of and from any and all cost, loss, damage, or liability resulting from and such disclosures(s).
    b) To Family and Responsible Party: Riverview Surgery Center, LLC and each attending or treating practitioner, UNLESS SPECIFICALLY INSTRUCTED OTHERWISE BY DELETING THIS SUBPARAGRAPH 2(b), are hereby authorized and directed, during the period of this admission, to disclose information to the patient's spouse, children, parents, and any other person authorized to consent to treatment pursuant to 431.061-.065, RSMO (1979) as amended, concerning the patient's health status, diagnosis, prognosis, and progress. Each of the undersigned do hereby release and hold Riverview Surgery Center, LLC, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss, damage, or liability resulting from or arising out of such disclosure(s).
3. **RELEASE OF RESPONSIBILITY FOR VALUABLES:** Riverview Surgery Center, LLC is hereby fully released of and from any and all responsibility for loss or damage to the personal property, money, or valuables of the undersigned patient.
4. **NOTICE OF PRIVACY PRACTICES:** I am aware of my rights to privacy of personal health information, under the Privacy Rule of Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
5. **PHYSICIAN OWNERSHIP DISCLOSURE:** Riverview Surgery Center, LLC provides services only to patients admitted by private practitioners who are members of the Riverview Surgery Center, LLC medical staff, some of whom retain joint ownership of the Riverview Surgery Center, LLC.
6. **FLAT RATE FEE:** Riverview Surgery Center, LLC charges a flat rate global fee for surgical services.
7. **TERMS FOR TREATMENT & FINANCIAL RESPONSIBILITY:** I understand that treatment deposit and/or acceptable hospitalization insurance is required for treatment in Riverview Surgery Center, LLC. Total balance is due on the day of surgery, with allowance made for insurance coverage APPROVED AND VERIFIED PRIOR TO TREATMENT. In accordance with above terms, and in consideration of Riverview Surgery Center, LLC's agreement to render treatment and furnish supplies, the undersigned patient and/or under signed surety, do hereby agree upon demand to pay Riverview Surgery Center, LLC, its agents or assigns, whatever the sums of money that shall become due on the account of the patient and that such liability shall be joint and several. It is agreed that if full payment is not made by insurance or other third party payors within thirty (30) days, the undersigned shall make payment in full. ANY PAST DUE BALANCES NOT PAID BY INSURANCE OR OTHER 3RD PARTY PAYER, SENT TO A COLLECTION AGENCY IS THE RESPONSIBILITY OF THE GUARANTOR AND HE/SHE AGREES TO PAY ALL COLLECTION FEES OR COURT COSTS.
8. **MEDICARE/CERTIFICATION AND AUTHORIZATION:** Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized to the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

9. **ASSIGNMENT TO INSURANCE AND THIRD PARTY BENEFITS:**
   a) **To the Riverview Surgery Center, LLC:** The undersigned, and each of them, do hereby assign, transfer, and set over unto Riverview Surgery Center, LLC all benefits payable to them or either of them now due and to become due and payable, including major medical benefits, by reason of this admission under any policy of insurance or other health care coverage in which the patient is a covered beneficiary.
   b) **To the Health Care Provider:** The undersigned parties do hereby assign, transfer, and set over unto the patient's health care providers, including their professional corporations or business entities, including without limitation, if applicable, Pathology Provider, Anesthesia Provider, and Radiology Provider, all benefits otherwise payable to the undersigned now due and to become due and payable, including major medical benefits, by reason of this Riverview Surgery Center, LLC admission under any policy or other health care coverage contract in which the patient is a covered beneficiary.
   c) **To Medicare:** The undersigned parties do hereby assign, transfer and set over any and all Medicare benefits payable for Riverview Surgery Center, LLC and health services relating to this admission to Riverview Surgery Center, LLC and to the patient's health care providers, including their professional corporations or business entities, including but not limited to, if applicable, Pathology Provider Name, Anesthesia Provider Name, Radiology Provider Name, and hereby authorize Riverview Surgery Center, LLC and said health care providers or their corporations to submit claims directly to Medicare for payment on behalf of the undersigned patient, items not covered by Medicare will be the responsibility of the undersigned financially responsible party.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS

DO NOT sign these authorizations without a full understanding of each.

NAME OF PATIENT _____ DATE _____

NAME OF AUTHORIZED REPRESENTATIVE TO DISCUSS ABOVE NAMED PATIENTS MEDICAL AND/OR FINANCIAL ISSUES IN THEIR ABSENCE _____ DATE _____

SIGNATURE OF PATIENT, AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY _____ DATE _____ _____ RELATIONSHIP

WITNESS _____ DATE _____

RIVERVIEW
Surgery Center, LLC

Date: _____

To: Out of Network Members

Re: Non-Participating Provider Agreement

Patient: _____

Account: _____

It is the intention of Riverview Surgery Center, LLC to extend “in-network benefits” to all of our patients. Your insurance company will pay the surgery center as a non-participating provider and it is our intention to honor their payment without additional cost to you than if we were a participating or “in-network” provider. It is possible that your insurance payment for your visit to Riverview Surgery Center, LLC will be sent directly to you. In the event payment is sent directly to you, please endorse the check over to the center, and mail the check along with the Explanation of Benefits you will receive from your insurance provider. By sending such payment you receive directly to the center you avoid the possibility of additional costs for using our facility. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and to make any necessary adjustments without the need to bill you for services due to non-payment.

_____ _____

Patient/Responsible Party Date

_____ _____

Witness Date

1276 N. Plaza Drive, Rockport, IN 47635
Phone: 812-649-2500 Fax: 812-649-9427

RIVERVIEW
Surgery Center, LLC

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OR FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chosen action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chosen action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of the assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____

Patient Signature Date

PATIENT LABEL