Emmaus Surgical Center 57 Route 46, Suite 104 Hackettstown, NJ 07840 Tel: 908-813-9600	, DOB: 01/00/1900 MRN: , 00000 DOS: 01/00/1900 Insurance: Dr.

Authorization to Release Information and Pay Facility/Anesthesiologist Directly

1. I authorize *Emmaus Surgical Center, LLC* to release to appropriate third parties such information as may be necessary, including my diagnosis and other information from my medical records for the purpose of processing my facility and/or anesthesia claim(s) ('bills").

2. I authorize all health insurance payments for services rendered to be sent directly to *Emmaus Surgical Center, LLC* and/or Emmaus Anesthesia Associates, LLC. These amounts shall not exceed the balance of the Facility and/or Emmaus Anesthesia Associates, LLC's charges for these services. This is a direct assignment of my insurance policy.

3. I understand that I am financially responsible to *Emmaus Surgical Center, LL* C and/or Emmaus Anesthesia Associates, LLC for all charges not covered by insurance. I understand that I or my insurance company may receive more than one charge originating from different sources for this procedure. For example, separate fees may originate in addition to the physician's fee and will be billed separately (i.e. anesthesiology, facility, laboratory and radiology fees).

4. I acknowledge that the insurance information that I have provided is accurate and true.

5. I understand that in the event of an emergency or the need for extended care, I may be transferred to a hospital or may need to seek treatment at an Emergency Room within 24 hours after having my procedure performed. In either case, I authorize Emmaus Surgical Center, LLC to obtain a copy of my "Discharge Summary" so as to provide the Center with appropriate follow-up information.

6. I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct and I authorize Emmaus Surgical Center, LLC and/or Emmaus Anesthesia Associates, LLC to release to the Medicare Bureau, CMS, and/or its intermediaries or carriers any information about me needed for this claim including any medical information relating to my treatment.

7. I understand that I should not bring any valuables to *Emmaus Surgical Center, LLC* and that the Center is not liable for theft or loss of any valuables.

8. Prior to the date of my procedure, I have been informed that the physician who is rendering services has ownership/interest in Emmaus Surgical Center, LLC, and I have been offered the option to be treated at another facility. I wish to be treated at the above referenced facility.
9. A copy of the Patient's Rights and Responsibilities has been given to me or to my representative prior to surgery.

10. A copy of the HIPPA Notice of Privacy for *Emmaus Surgical Center, LLC* has been offered to me or to my representative.

11. I understand that a responsible adult must be present to drive me home from the Center unless my physician gives me an exemption. I also acknowledge that I have a responsible adult, whose care I will be under for the next 24 hours.
Name of Responsible Adult: _____ **Home Phone:** _____ **Work Phone:** _____

ADVANCE DIRECTIVES/POLST WAIVER: I have previously executed an Advance Directive: □ **Yes** □**No**
I have previously executed a **POLST** (Physician's orders for life sustaining treatment): □ **Yes** □**No**

Please read the following important information:

If I do not have a previously executed Advance Directive, I acknowledge having been given information regarding this prior to my procedure.

12. Some of the procedures and medications used during your surgery could be similar to procedures and medications specified in Advanced Directives and a POLST. Therefore to insure the best possible care during your surgery, you MUST waive your Advance Directives during your admission to the Center and recind your POLST, if applicable, for the duration of your procedure at the Center.
13. I acknowledge that all resuscitative measures will be taken during my stay at the Center, and I further understand that if I have ever signed an Advance Directive or have a POLST, **I temporarily waive them in their entirety for the duration *of my visit at Emmaus Surgical Center, LLC.***

By signing here, I agree to all thirteen (13) authorizations on this page.

_____	_____	_____
Patient Signature	Parent/Guardian/Representative (If patient is unable or too young to sign)	Date
_____	_____	_____
Printed Name	Printed Name/Relationship	Witness