Sequoia
Surgical Pavilion

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I hereby assign to and authorize payment directly to the facility named above (the "facility") of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for facility charges, for services rendered by the facility.

A photostatic copy of this agreement shall be considered effective and valid as the original.

I irrevocably agree that the facility may disclose, to the extent allowed by law, my medical and financial record to (a) any affiliate of the facility specifically including NATIONAL SURGICAL HOSPITALS and its employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, or any person or entity responsible for all or part of the facility's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Health Care Financing Administration, any other governmental or accrediting agency, or their agents or employees.

All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payor. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney, patient monitoring agency or collection agency for collection, I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the facility files for reimbursement from my insurer or other payor as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amounts when and as due.

The undersigned authorizes to the extent necessary for the facility to obtain reimbursement for services rendered.

Facility employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

PATIENT _____ **DATE** _____ **GUARANTOR** _____ **DATE** _____

WITNESS _____ **DATE** _____

ADVANCE NOTIFICATION

I received an Advanced Notification form which provided me with my patient rights, information regarding the grievance process, physician ownership, and advanced directives, prior to consenting for surgery.

PATIENT/AUTHORIZED AUTHORITY _____ **DATE:** _____ **TIME:** _____

ADVANCE DIRECTIVES/LIVING WILL/HEALTH CARE PROXY

I understand I have the right to make choices regarding life-sustaining treatment (including resuscitative-measures).

- ☐ Yes, I have an Advance Directive/Living Will/Health Care Proxy. The facility has explained to me their policy regarding the honoring of this document (see Advance Notification form) and I agree to proceed with the proposed procedure as scheduled.
  - ☐ I have provided a copy to the facility
  - ☐ My directive is on file at
- ☐ 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.

For information on how to obtain an Advanced Directive/Living Will/Health Care Proxy visit the following website:
http://www.calhospital.org/resource/advance-health-care-directive

PATIENT/AUTHORIZED AUTHORITY _____ **DATE:** _____ **TIME:** _____