

**MEDICAL TREATMENT AGREEMENT (CONDITION OF ADMISSION)**

Patient or someone acting for the patient agrees to the following terms for patient care:

- 1) **MEDICAL TREATMENT:** Patient will be treated by his/her attending doctor or specialists. Patient authorizes Tucson Surgery Center to perform services ordered by the doctors. Special consent forms may be needed. Many doctors and assistants (such as those providing x-rays, lab tests, and anesthesiology) may not be Tucson Surgery Center employees and are responsible for their own treatment activities. Patient consents to the treatment to be provided by those doctors and technicians. Tucson Surgery Center may develop and establish certain criteria which will automatically trigger the performance of specific tests which patient agrees may be performed without any further separate consent.
- 2) **GENERAL DUTY NURSING:** Tucson Surgery Center provides only general nursing care. If the patient needs special or private nursing, it must be arranged by the patient or by the doctor treating the patient.
- 3) **MONEY AND VALUABLES:** Tucson Surgery Center has a safe in which to keep money or valuables. It will not be responsible for any loss or damage to items not deposited in the safe. Tucson Surgery Center will not be responsible for loss or damage to items such as glasses, dentures, hearing aids and contact lenses.
- 4) **TEACHING PROGRAMS:** Tucson Surgery Center participates in programs for training of health care personnel. Some services may be provided to the patient by persons in training under the supervision and instruction of doctors or Tucson Surgery Center employees. These persons may also observe care given to the patient by doctors and Tucson Surgery Center employees. Photos or video tapes may be made of surgical procedures.
- 5) **RELEASE OF INFORMATION:** The Surgicenter or a treating provider may disclose all or any part of the patient's medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, OR CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION), to the following:
  - a. **Third Parties:** Including but not limited to any person or corporation, or their designee, which may be liable under contract to Tucson Surgery Center, any other party, the patient, a family member, or employer of the patient, for payment of all or part of a provider's charges, such as insurance companies, workers' compensation payers, Tucson Surgery Center or medical service companies, welfare funds, governmental agencies or the patient's employer; quality assurance and peer review committees, subcommittees, ad hoc committees, or consultants; utilization review organizations; medicare review organizations; Tucson Surgery Center accrediting surveyors; treating physicians; and Tucson Surgery Center and treating physician's professional liability insurance carriers.
  - b. **Medical Audit:** Tucson Surgery Center conducts a program of medical audit and the patient's medical information may be reviewed and released by employees, members of the medical staff or other authorized persons to appropriate agencies as part of this program.
  - c. **Medical Research:** Information may be released for use in medical studies and medical research.
  - d. **Other Health Care Providers:** Information may be released to other health care providers in order to provide continued patient care.

I understand that the authorization granted in items 5.a,b,c and d may be revoked by me at any time, except to the extent to which action has been taken in reliance upon it. The authorization will stay in effect as long as the need for information in items 5.a,b,c and d exists.

I have read and understand this Admissions Agreement, have received a copy and I am the patient, the parent of a minor child or the court appointed guardian for the patient and am authorized to act on the patient's behalf to sign this Agreement.

**PATIENT SELF-DETERMINATION ACT:**

I acknowledge that I have been given information regarding this state's law on living wills and advance directives. Advance directives are documents such as living wills, durable power of attorney, health care surrogate appointments. Please initial the Following Applicable Statements:

- \_\_\_\_\_ I have executed an Advance Directive and have been requested to supply a copy to Tucson Surgery Center.
- \_\_\_\_\_ I have reviewed the Advance Directive on file at Tucson Surgery Center and it is my current Advance Directive.
- \_\_\_\_\_ I have not executed an Advance Directive.
- \_\_\_\_\_ I have received information about Advance Directives as required by federal law.
- \_\_\_\_\_ Do you wish to execute an Advance Directive at this time?
- \_\_\_\_\_ If yes, DNR waiver is to be signed.
- \_\_\_\_\_ **I have received a copy of *Your Rights As A Patient*.**

**FINANCIAL AGREEMENT**

I agree that in return for the services provided to the patient by Tucson Surgery Center or other health care providers, I will pay the account of the patient, and/or prior to discharge make financial agreements satisfactory to Tucson Surgery Center or any other providers for payment. If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses. The amount of the attorney's fee shall be established by the Court and not by a Jury in any court action. A delinquent account may be charged interest at the legal rate. If an account is sent to an agency for collection, I agree to pay collection fees, equating up to 50% of the outstanding balance at the time the account is placed with the agency.

**When paying by check towards any amount that may be due by the patient,** I understand that if the check is returned unpaid, the checking account will be debited electronically for both the face amount on the check and a \$25.00 service charge. This will be in addition to any charges assessed by my financial institution as a result of the dishonored check, as provided for by A.R.S. 44-6852.

I request that payment of any authorized Medicare benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

If any signer is entitled to benefits or any type whatsoever under any policy of insurance insuring patient, or any other party liable to patient, that benefit is hereby assigned to Tucson Surgery Center or to the provider group rendering service, for application on patient's bill. **HOWEVER, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL.**

**IN GRANTING ADMISSION OR RENDERING TREATMENT, TUCSON SURGERY CENTER AND OTHER PROVIDERS ARE RELYING ON MY AGREEMENT TO PAY THE ACCOUNT. EMERGENCY CARE WILL BE PROVIDED WITHOUT REGARD TO THE ABILITY TO PAY.**

\_\_\_\_\_  
PATIENT

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

\_\_\_\_\_  
OTHER PARTY AGREEING TO PAY

\_\_\_\_\_  
RELATIONSHIP TO PATIENT