PATIENT NAME:

PATIENT ID:

FACILITY:

PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY FORM

By signing this Patient Authorization and Financial Responsibility Form ("Form"), I understand that I am personally responsible for the payment of vascular access procedures and other services that I receive at the above-listed outpatient facility ("Facility") that is managed/operated by Lifeline Vascular Access ("Lifeline"), at Facility's usual and customary fees (available for review upon request). My financial responsibility shall continue until insurance carriers reimburse Facility/Lifeline for such services, or Facility/Lifeline releases me from responsibility.

In return for Facility's treatment and services, I agree to the following:

1. **Assignment of Benefits; Lien.** I hereby assign to Facility/Lifeline all of my rights, title and interest in any cause of action and/or payment due to me (or due to my dependants or my estate) under any employee benefit plan, insurance plan, union trust fund, or similar plan ("Plan"), under which I am a participant or beneficiary for services, drugs or supplies provided by Facility ("Services") to me or my dependants. I also hereby designate Lifeline as a beneficiary under any such Plan, and instruct that any payment be made solely and sent directly to Facility/Lifeline. If I receive any payment directly from any Plan for Services provided to me or my dependants by Facility, I agree to immediately endorse and forward such payment to Facility/Lifeline. I agree that Facility/Lifeline shall have an automatic lien against any such payment I receive from any Plan. **If I fail any of my obligations under this provision, I understand that Facility/Lifeline may pursue collections and legal action against me. In this case, I shall be responsible for the costs of collection (including reasonable attorneys' fees) that are incurred by Facility/Lifeline.**

2. **Collection of Benefits/ Legal Action.** I agree to assist and cooperate with Lifeline to obtain payment from any Plan for Services, provided to me (or my dependants) by Facility. This includes, without limitation, my participation as a plaintiff in litigation, arbitration, appeal or other action or lawsuit, at Facility's expense, arising from dispute between Facility/Lifeline and any of the Plans relating any payment for my Services by Facility that is alleged by Lifeline.

3. **Lifeline as Authorized Representative.** I hereby authorize Facility/Lifeline (including its attorneys and/or representatives) to act on my behalf or my dependant's or my estate's behalf, in pursuing benefit claims or appeals of adverse benefit determinations under any Plan. I hereby authorize Facility/Lifeline and its attorneys to pursue all available legal rights and remedies that they deem appropriate in order to collect from the Plans for such Services. I hereby agree to follow procedures established by any Plan to authorize Facility/Lifeline in this capacity.

4. **Patient Deductible, Coinsurance and Co-payment.** For Medicare and certain other insurance companies where Facility accepts the charge determination as full payment, I am responsible only for my annual deductible, coinsurance and my co-payments, if any. If I am a Medicare beneficiary, such financial responsibility may apply to Lifeline performed clinical laboratory services.

5. **Spend Down and Share of Cost (SOC).** I understand that if I participate in a State Medicaid program with a spend down, SOC or other cost sharing program that requires me to share in the cost of my healthcare, I agree to pay the amount of the spend down, SOC or other cost sharing at the time services are rendered, or when the spend down, SOC or other cost sharing amount is billed to me.

6. **Successors, Heirs and Estate.** I desire that the obligations and representations contained in this document be binding on my heirs, legal representatives, successors and my estate. I agree not to assign my benefits under any Plan to any other person or firm for Services provided to me or my dependants by Facility.

   This Form shall continue during treatment from Facility and thereafter, until Facility/ Lifeline is paid in full for Services provided to me or my dependants by Facility, or Facility/Lifeline's claim for payment is settled or withdrawn. I understand that if I do not fulfill the above terms and conditions, Facility/Lifeline may pursue payment from me directly, as appropriate, and/or ask me to immediately transfer to another vascular access center.

   If any part of this form is deemed unenforceable, the remaining provisions shall remain in full force and effect. I understand I can hire an attorney at my expense to represent me in connection with this Form.

This Form has been explained to me in person by the Lifeline teammate identified below:

Print Patient/ Representative Name: _____ Print Teammate Name: _____

Representative Relationship to Patient: _____
(If Applicable)

Date: _____ Date: _____

Patient or Representative Signature: **Teammate Signature:**

_____ _____

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A Patient's Safety Education

It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient safety education. It is in recognition of these factors that these rights and responsibilities are affirmed.

1. The patient has the right to report any concerns regarding safety to The Joint Commission.

2. The patient understands the importance and necessity for time-out procedure and marking the surgical site prior to the start of procedures.

3. The patient understands the importance and necessity for using correct identifiers for patient name and procedure to be preformed.

4. The patient understands what process and procedures are done at this center to prevent infection and adverse events.

PATIENT RESPONSIBILITIES

It is the patient's responsibility to fully participate in decisions involving his/her own safety and to accept the consequences of these decisions if complications occur.

Patient signature: _____ Date: _____

Witness: _____ Date: _____

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Access Center Name: _____

ACCESS CENTER PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVES OR MEDICAL POWERS OF ATTORNEY

All patients have the right to participate in their own healthcare decisions and to make advance directives or execute Powers of Attorney that authorize others to make decisions on their behalf based on the patients' expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Access Center respects and upholds those rights.

However, unlike in an acute care hospital setting, this Access Center does not routinely perform high-risk procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risk, your expected recovery and care after your surgery.

Therefore, per our Rights of Patient policy regarding Advance Directives, regardless of the contents of any advance directive or instruction from a Health Care Surrogate or Attorney, if an adverse event occurs during your treatment at this Access Center we will initiate resuscitative or other stabilizing measures and transfer you to an Acute Care Hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measure already begun will be ordered in accordance with your wishes, Advance Directive or Healthcare Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure or to provide you with a list of facilities for your consideration that may agree to perform the procedure without suspending your Advance Directives.

Please check the appropriate box in answer to these questions. Have you executed an Advance Health Care Directive, a Living Will, a Power of Attorney that authorizes someone to make Health Care decisions for you?

- ☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.
- ☐ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.
- ☐ I would like to have information on Advance Directives.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.

By: _____
(Patient's Signature)

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	DATE

If consent to the procedure is provided by anyone other than the Patient, this form must be signed by the person providing the consent or authorization.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED.

By: _____
(Signature)

_____
(Print Name)

RELATIONSHIP TO PATIENT

- ☐ Court Appointed Guardian
- ☐ Attorney in Fact
- ☐ Health Care Surrogate
- ☐ Other _____

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9. **The patient** has the right to be advised if this ambulatory surgery facility proposes to engage in or perform human experimentation affecting his/her care of treatment. The patient has the right to refuse to participate in such research projects.

10. **The patient** has the right to reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient's continuing health care requirements following discharge.

11. **The patient** has the right to examine and receive an explanation of his/her bill regardless of the source of payment.

12. **The patient** has the right to know what facility rules and regulations apply to his/her conduct as a patient.

13. **The patient** has a right to request information about the grievance process at the Center. If a patient has a grievance with the Center, he/she has the right to speak immediately with the Clinical Director or the substitute person assigned to answer to grievances. A formal written grievance may be completed for further review of the grievance.

14. **The patient** has a right to be free from chemical, physical and psychological abuse or neglect.

PATIENT RESPONSIBILITIES

It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur.

The patient is expected to follow up on his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels is necessary

Date:_____

Patient Signature_____ Witness_____

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A Patient's Bill of Rights

It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. **The patient** has the right to considerate and respectful care.

2. **The patient** has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his/her behalf. He/she has the right to know, by name, the physician responsible for coordinating his/her care.

3. **The patient** has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to know the name of the person responsible for the procedures and/or treatment.

4. **The patient** has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.

5. **The patient** has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. Those not directly involved in his/her care must have permission of the patient to be present.

6. **The patient** has the right to expect that all communications and records pertaining to his/her care will be treated as confidential.

7. **The patient** has the right that within its capacity, this ambulatory surgery facility must provide evaluation, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8. **The patient** has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him/her.

3. Ending This Authorization

Select on of the following two choices:

- ☐ This authorization will end of the following date: _____
- ☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

_____

4. Changing Your Mind About This Authorization

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any action taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

5. Signing This Authorization is Note a Condition of Treatment

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected heath information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. Possibility of Redisclosure

I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

7. Individual Patient's Signature

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative of the individual patient:

Personal representative's name: _____
Print name

_____
Signature

Relationship to patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.

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Individual Patient's Authorization

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

Psychotherapy notes: ____ Check here if this authorization is for psychotherapy notes

If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected heath information.

1. Individual Patient (or Personal Representative) Confirming the Authorization

I give my authorization to use or disclose my protect health information as described in Section 2 below. I give this authorization voluntarily.

Your name: _____

Your street address: _____

Your city: _____ State: _____ ZIP: _____

Your telephone number: _____

Your email address: _____

Your patient account number: _____

2. The Use and/or Disclosure Authorized

Describe in detail the protected health information you are authorizing to be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed here):

Access procedure

Name of people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or disclose the protect health information described above.

Medical provider

Name the people and/or organizations (or the kinds of people and/or organizations) that your are authorizing to receive and use your protected health information.

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

Medical care

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Privacy Practices Acknowledgement

Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's name: _____ DOB: _____

Patient's signature: _____ Date: _____

Original to chart – copy to patient

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