Elite Center
for Minimally Invasive Surgery

6655 Travis, Suite 200
Houston, Texas 77030
713-595-5900

Financial Agreement

FINANCIAL AGREEMENT - The undersigned agrees, whether he signs as agent or a patient, that in consideration of the services to be rendered to the patient, he hereby is responsible for paying facility copayments, deductibles, estimated facility coinsurance amounts, and any balance deemed not to be a covered benefit of the insurance policy. Monthly statements will be sent to guarantors for patient balances. Acceptable means of payment are cash, money order, cashier's check, credit card, or personal check. Cosmetic surgery procedures must be paid in full prior to surgery.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATON TO RELEASE INFORMATION - In consideration of services rendered, I hereby transfer and assign to the hospital and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance.

I have presented my insurance card and photo identification and assign all right to payment due me for medical and/or surgical services under said policies to Elite Center for Minimally Invasive Surgery, my attending physician, consulting physician, anesthesiologist, radiologists, ER physicians, professional laboratory and pathological services. I recognize the above physicians are independent contractors who will generate separate bills for their respective services. Elite Center for Minimally Invasive Surgery provides cost estimates and generates bills for the facility portion only. I understand I am financially responsible for the above physician's services.

I authorize Elite Center for Minimally Invasive Surgery and/or physicians indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, health or hospital plan.

MEDICARE PAYMENTS - (Patient's Certification, Authorization to Release Information, and Payment Request) I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PERSONAL VALUABLES AUTHORIZATION - I have been informed and understand that the hospital **WILL NOT ASSUME RESPONSIBILITY** for any personal property I may bring and/or keep in the hospital during my stay at Elite Center for Minimally Invasive Surgery.

ADVANCED MEDICAL DIRECTIVE/PATIENT RIGHTS AND RESPONSIBILITIES - I have been given written materials about my right to accept or refuse medical treatments and have been informed of my rights to formulate Advanced Directives ❑ YES ❑ NO. I also acknowledge receipt of a written statement regarding my rights and responsibilities as a patient, which tells me how to register any complaint I might have.

CONDITIONS OF COVERAGE DOCUMENTS – I have been presented the required Conditions of Coverage Documents, prior to the date of my procedure.

ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER - I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, the hospital may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PATIENT OR IS DULYAUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

____________________ ______________________________________

Date Patient, Patient's Agent or Representative

________________________________ ______________________________

Witness Relationship to Patient

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Elite Center
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Patient Bill of Rights and Responsibilities

Patient Bill of Rights and Responsibilities:

Patients and families are our number one concern. It is a priority at Elite Center for Minimally Invasive Surgery that patients and families are as comfortable as possible during their stay at ECMIS. The following statement of patient rights and responsibilities is present as the policy for ECMIS, but does not presume to be a complete representation of all mutual rights and responsibilities.

Patient Rights:

1. To reasonable access to the medical resources at ECMIS without regard to race color, national origin, age, sex, disability or financial status.
2. To receive considerate, respectful, and compassionate care.
3. To be informed about and to participate in decisions regarding your care including the refusal of treatment.
4. To be involved in all aspects of care, and to be allowed to participate in that care.
5. To information about advance directives that would allow you to make your own healthcare decisions for the future and to have your chosen representative exercise these rights for you if you are not able to do so.
6. To be assured that our provision of care for you will not be conditioned on your advance directives.
7. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of your actions.
8. To have clinical and educational information about your treatment in language and terms that you understand.
9. To voice complaints about your care, and to have those complaints reviewed and, when possible, resolved.
10. To have access to organizational leaders if an ethical, cultural or spiritual dilemma presents itself.
11. To information about any research activities that involve your treatment, including benefits and risks, procedures involved, and alternative treatments.
12. To security, privacy, and confidentiality in all patient care areas as you undergo tests or treatment.
13. To know who is responsible for providing your immediate, direct care.
14. To information about the financial aspects of services and alternative choices.
15. To be supported in accessing protective services when requested.
16. To unrestricted communication unless restrictions are a part of your treatment. Any restrictions will be explained to you and will be reviewed as your treatment changes.
17. The surgery center provides for the safety and security of patients and their property.
18. Patients who desire private telephone conversations have access to space and telephones appropriate to their needs and the care, treatment, and services provided.
19. To request an itemized statement of billed services.

Patient Responsibilities:

1. To give your doctor and the ECMIS staff complete and accurate information about your condition and care, including the reporting of unexpected changes in your condition to your physician and nurse.
2. To follow the orders and instructions given by your doctor and instructions given by the staff for your care, including keeping follow-up appointments after discharge.
3. To report unexpected changes in your condition to your physician and nurse.
4. To bring a current copy of your advance directives to be placed in your medical record prior to the time of your admission.
5. To accept responsibility for refusing treatment.
6. To show consideration for other patients by following all rules and regulations pertaining to smoking, visitors, noise and general conduct.
7. To accept financial obligations associated with your care.
8. To be considerate of staff members who are caring for you. A mutual spirit of respect and cooperation allows us to serve you best.
9. To advise your nurse, physician, caregiver and/or the business office staff of any dissatisfaction you may have regarding your care.

Patient Satisfaction:

- ❖ Assessment of patient/family satisfaction is most important to us. A patient satisfaction evaluation is given to all patients at discharge. Every attempt is made by the nurse to contact each patient within 24-48 hours after discharge.
- ❖ Please let us know how we can improve our service to you.

Physician Ownership:

- ❖ There may be one or more of the physicians providing treatment at Elite Center for Minimally Invasive Surgery that has an ownership interest in the surgery center. Patients have a right to choose the provider of their healthcare services.

Advance Directive Policy:

- ❖ Elite Center for Minimally Invasive Surgery does not honor advance directives or living wills. Patients with an advance directive or living will may bring it to the center and in the event of transfer to another facility, we will forward it with the patient's medical records and further consideration will be made at that time.

Voicing Complaints:

Our staff strives to provide excellent care and service. If we fail to meet your expectations in any way, please do not hesitate to let us know as soon as possible. Rest assured that voicing a concern will never adversely affect the care and service we provide. Usually, a word to your nurse or Director of Nursing is all that is needed, but if you prefer, you can contact the Administrator of the Elite Center for Minimally Invasive Surgery. Your question or concern will be promptly addressed. You also have the right to register a complaint with the Texas Department of Health and/or the Centers for Medicare & Medicaid Services (CMS) at 1-800-Medicare. You may also contact the Office of the Medicare Beneficiary Ombudsman at www.medicare.gov/Ombudsman/activities.asp.

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