SPOKANE VALLEY Ambulatory Surgery Center

Have you had surgery at this facility before? Yes No If so, what year? _____

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN: _____ Marital Status: S M W D O Sex: M or F

Mailing Address: _____

Physical Address: _____

City/State/Zip Code: _____

Telephone: ☐H _____ ☐ W_____ ☐ C_____

Email: _____

Employer: _____ Occupation: _____

Guarantor (Responsible Party) Please fill out entirely if the patient is a minor

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN: _____ Relationship: _____

Mailing Address: _____

Physical Address: _____

City/State/Zip Code: _____

Telephone: (H) _____ (W) _____ (C) _____

Employer: _____ Occupation: _____

Emergency Contact (Friend or Relative with a separate number than already listed)

Name: _____ Relationship: _____ Phone#: _____

INSURANCE INFORMATION – Primary

Name of Insurance Co.:_____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy holder Date of Birth: _____ SSN: _____

Employer/Group Name: _____

Insured ID #: _____ Policy Group #: _____

INSURANCE INFORMATION – Secondary

Name of Insurance Co.:_____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy holder Date of Birth: _____ SSN: _____

Employer/Group Name: _____

Insured ID #: _____ Policy Group #: _____

CONSENT TO TREATMENT

1. The patient named below hereby voluntarily consents to the rendering of Ambulatory Surgical Care, which may include routine diagnostic procedures, whether tests or otherwise, and such medical and surgical treatment, including but not limited to, anesthesia, x-ray procedures, blood tests, and laboratory tests as the attending physician(s) or other consulting physicians consider to be necessary. I understand that I must look solely to the attending physician(s) for interpretation of the results of any diagnostic procedure or test, and medical and surgical treatment.

2. The patient has a general understanding of the nature and purpose of his/her medical treatment and contemplated operation(s) and is generally aware that medical complications can occur. The patient acknowledges that no guarantees have been made as to the result of examination or treatment in this facility.

3. The patient understands that one or more of the Physicians providing treatment at Spokane Valley Ambulatory Surgery Center may have ownership interest in Spokane Valley Ambulatory Surgery Center. The patient also acknowledges that he/she has the right to choose the provider of his/her healthcare services and has chosen Spokane Valley Ambulatory Surgery Center. Further, the patient realizes that among those who attend patients at this facility are medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care as a part of their education. Still or video pictures and closed circuit television monitoring of patient care may be used, unless a patient expressly requests otherwise.

4. The patient requests the facility authorities to dispose of any tissue that may be removed from him/her.

5. For anyone 18 years of age or older, we are required by law to ask if you have an Advanced Directive. If you do have an Advanced Directive, a "Living Will", or Durable Power of Attorney and provide us with a copy, it will be placed in the patient's chart. However, it will be suspended while in the care of SVASC. In the event that the patient is transferred to an acute care facility, a copy of the document will be provided to that facility.
   I have an Advanced Directive yes no

The patient has read this form, and is satisfied that he/she understands its content and significance.

Dated: _____

_____ _____
(Signature of Patient) (Witness)

_____ _____
(Patient's Agent or Rep. or Guarantor) (Relationship to Patient)

I understand I am responsible for payment of my account regardless of insurance coverage. I authorize SVASC to give my insurance company or companies any and all information they may require concerning my case. I authorize payment to be made directly to SVASC by my insurance company. I further authorize my insurance company to pay the Anesthesiologist directly.

I request that payment of authorized Medicare benefits be made on my behalf to Spokane Valley Ambulatory Surgery Center for any services furnished to me by SVASC or the Anesthesiologist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If a secondary insurance is listed, my signature authorizes releasing the information to the insurer or agency shown. SVASC accepts the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

My signature certifies I have read and understand the above statements.

Signature: _____ Date: _____
(Patient or Parent/Legal Guardian)