SOUTH ATLANTA AMBULATORY
SURGICAL CENTER

TO: OUT OF NETWORK MEMBERS

RE: NON-PARTICIPATING PROVIDER

DATE OF SERVICE: _____

PATIENT: _____

Thank you for scheduling your procedure at South Atlanta Ambulatory Surgical Center. Your physician designed this facility with you in mind, and recommended treatment here to provide you with the highest level of patient care. We are proud to serve you and are committed to meeting your healthcare needs in a state of the art environment, with a first rate staff and excellence in patient satisfaction.

Although South Atlanta Ambulatory Surgical Center is not currently a participating provider with your Insurance Plan, we strive to give our patients the best possible value for their health care dollar. While we cannot waive the patient responsibility required by your health plan, we are able to extend a significant discount if the estimated cost of your procedure is paid in advance. We also offer a discounted rate if the cost of your procedure is paid within 30 days or 60 days from your date of service. The same discounts are extended to your health plan as well. Our discount program allows us to provide access to superior quality care to all patients in the community, regardless of insurance type, at a cost-effective rate for you, your family and your health plan.

A member of our staff will call you approximately one week prior to surgery to discuss pre-operative orders and your insurance coverage. We will provide you with a cost estimate for your upcoming procedure, and the amount of payment due at the time of service, as well as payment options available. Once you are fully informed of the Financial Policies, you will be asked to agree in advance as to how you would like to pay for services, and all relevant forms will be presented for signature upon check in. We are confident in our competitive pricing, and are willing to match a lower price you are offered from an area hospital, if you wish to provide a copy of their estimate.

We will submit a claim to your insurance company on your behalf, and it is possible that the insurance payment for your visit will be sent directly to you. We ask that you please endorse the check over to the facility, and mail it, along with your Explanation of Benefits. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and make any necessary adjustments.

If you have any questions or concerns, please do not hesitate to call our billing office at 844-296-7768 toll free between the hours of 8:00-3:00 Mon-Fri.

We look forward to serving you, and appreciate being your preferred choice for surgical care.

830 Eagles Landing Parkway Suite 101
Stockbridge, GA 30281-7366

SOUTH ATLANTA AMBULATORY SURGICAL CENTER

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS, & DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, under any policy of insurance or other health care coverage in which the patient is a covered beneficiary, otherwise payable to me for services, treatments, therapies, including major medical, rendered or provided by the above-named health care provider, including their professional corporations or business entities, including without limitation, if applicable, pathology provider, anesthesia provider, and radiology provider by reason of this admission, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chosen action arising under any group health plann, employee benefits plan, health insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, including major medical, provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me;(2) submit evidence;(3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chosen action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Medicare: The undersigned parties do hereby assign, transfer and set over any and all Medicare benefits payable for health services relating to this admission to the above-named health care provider, including their professional corporations or business entities, including but not limited to, if applicable, pathology provider, anesthesia provider, and radiology provider, and hereby authorize said healthcare providers or their corporations to submit claims directly to Medicare for payment on behalf of the undersigned patient. Items not covered by Medicare will be the responsibility of the undersigned financially responsible party.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it ws the original. **THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.**

_____

NAME OF PATIENT

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED REP & FINANCIALLY RESPONSIBLE PARTY | RELATIONSHIP | DATE

_____ _____

WITNESS | DATE

PATIENT LABEL HERE

SOUTH ATLANTA AMBULATORY
SURGICAL CENTER

AUTHORIZATIONS & DISCLOSURES

These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

_____ **AUTHORIZATION FOR MEDICAL TREATMENT:** The undersigned hereby authorizes any anesthesia, medical or surgical treatment, including services rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated, as may, in their professional judgment be deemed necessary or beneficial for the purposes of diagnosis, treatment and medical care at South Atlanta Ambulatory Surgical Center. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.

_____ **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** For purpose of reimbursement, South Atlanta Ambulatory Surgical each attending or treating practitioner, including, but not limited to, pathology, anesthesia, radiology and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third party reimbursement or which could otherwise be harmful or prejudicial to my interests. Unless specifically instructed otherwise, South Atlanta Ambulatory Surgical Center and each attending or treating practitioner are hereby authorized and directed, during the period of this admission, to disclose information to the patient's spouse, children, parents, and any other person authorized to consent to treatment pursuant to 431.061-.065, RSMO (1979) as amended, concerning the patient's health status, diagnosis, prognosis, and progress. Each of the undersigned do hereby release and hold South Atlanta Ambulatory Surgical Center, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss damage, or liability resulting from or arising out of such disclosures.

_____ **RELEASE OF RESPONSIBILITY FOR VALUABLES:** South Atlanta Ambulatory Surgical Center is hereby fully released of and from any and all responsibility for loss or damage to the personal property, money, or valuables of the undersigned patient.

_____ **NOTICE OF PRIVACY PRACTICES:** I am aware of my rights to privacy of personal health information, under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 {HIPAA) and am aware that a copy of these rights are available to me upon request.

RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received, prior to my procedure, a copy of the Patient Rights and Responsibilities, which includes information regarding where and how I can file a grievance or complaint_

_____ **PHYSICIAN OWNERSHIP DISCLOSURE:** South Atlanta Ambulatory Surgical Center provides services only to patients admitted by private practitioners who are members of the Medical Staff, some of whom retain joint ownership of the surgery center. I understand I may choose another facility for the services I require, and have elected to receive
_____ care at South Atlanta Ambulatory Surgical Center Current Owners: **Surg Center Development; Dozier Hood, MD; Howard Herman, MD; Danko Cerenko, MD; Paul Free, MD; Young An, MD; Blanca Durand, MD and Michael Avidano, MD**.

_____ **TRANSPORTATION RELEASE:** I understand that the anesthetic to be administered to me may have effects that make it hazardous for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. I understand that South Atlanta Ambulatory Surgical Center will not perform my schedule procedure unless these arrangements are met, and have provided South Atlanta Ambulatory Surgical Center with my designated responsible party's name and phone number. The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.

Name of whom is driving the patient home **Phone Number**

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at South Atlanta Ambulatory Surgical Center and I understand that the center policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact} is to initiate resuscitative measures, should an adverse event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney. Please check one of the following:

O YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record

O YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me

O NO, I do not have an Advanced Directive/Living Will/Health Care Proxy

O I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to South Atlanta Ambulatory Surgical Center for any and all charges associated with the services rendered by South Atlanta Ambulatory Surgical Center, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. South Atlanta Ambulatory Surgical Center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insura nce carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all of the charges, South Atlanta Ambulatory Surgical Center will pursue the internal appeals provided by the health plan, and will only bill the patient for any amounts which remain outstanding after the appeals are exhausted I further acknowledge:

1. South Atlanta Ambulatory Surgical Center may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.
2. South Atlanta Ambulatory Surgical Center bills both patients and health plans using the same fee schedule, and my financial obligation is based on my applicable benefit levels associated with services for which South Atlanta Ambulatory Surgical Center will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, tiered prompt pay discounts off the estimated charges are offered equally to health plans and patients, in accordance with the South Atlanta Ambulatory Surgical Center Financial Policies, a copy of which is available to me upon request.
4. I am aware of my right to request a complete written estimate of the anticipated charges, and my associated financial responsibility. I understand that the fee quoted to me for the surgery facility is an ESTIMATE only, and it is possible that I will receive a bill for any balance which I remain financially obligated to pay.
5. Fees for anesthesia services, physician fees, pathology services, laboratory fees, durable medical equipment and surgical assistants, or other services rendered which are not included in the facility global rate will be billed separately where applicable.
6. When a payment is received by the patient, directly from the health plan they have assigned to South Atlanta Ambulatory Surgical Center, patient must endorse and forward the payment and Explanation of Benefits to South Atlanta Ambulatory Surgical Center as soon as the payment is received to avoid additional financial liability.

MEDICARE CERTIFICATION AND AUTHORIZATION: Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized by the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.

NAME OF PATIENT

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY RELATIONSHIP DATE

WITNESS DATE

NOTICE OF PRIVACY PRACTICE

Insurance Portability and Accountability Act of 1996 (HIPAA)

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

South Atlanta Ambulatory Surgical Center (SAASC) is required by law to maintain the privacy of your health information to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at South Atlanta Ambulatory Surgical Center please see the contact information at the end of this document.

1. HOW SAASC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

SAASC collects and protects the privacy of your health information. The law permits South Atlanta Ambulatory Surgical Center to use or disclose your health information for the following purposes:

1. TREATMENT: SAASC may use your health information to provide you with medical treatment for services. For example, information obtained from you by a front office personnel or nurse is necessary to determine what treatment you should receive.
2. PAYMENT: SAASC may use and disclose health information about you for payment for treatment and services you receive. For example, your health information may be sent to a third party payer such as an insurance company or health plan in order for SAASC to receive payment for services rendered.
3. HEALTHCARE OPERATIONS: SAASC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to evaluate the performance of our staff; assess the quality of care and outcomes in your case and similar cases; and to determine how to continually improve the quality and effectiveness of the health care we provide.
4. INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION: You may give SAASC written authorization to use or disclose your health information.
5. NOTIFICATION AND COMMUNICATION WITH FAMILY: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. REQUIRED BY LAW: As required by law, SAASC may use and disclose your health information. For example, SAASC may disclose health information for the following reasons; judicial and

administrative proceedings, to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the public or safety of a particular person or the general public.

7. PUBLIC HEALTH: As required by law, SAASC may use and disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief, and reporting disease or infection exposure.
8. HEALTH OVERSIGHT ACTIVITIES: SAASC may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.
9. DECEASED PERSON INFORMATION AND ORGAN DONATIONS: SAASC may disclose your health information to coroners, medical examiners, funeral directors, or to organizations involved in procuring, banking or transplanting organs and tissues.
10. RESEARCH: SAASC may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
11. WORKER'S COMPENSATION: SAASC may disclose your health information as necessary to comply with worker's compensation laws.
12. MARKETING: SAASC may contact you to give you information about treatments or health -related benefits and services that may be of interest to you.
13. GOVERNMENT FUNCTIONS: Specialized government functions such as protection of public officials or reporting to various branches of the armed services may require use or disclosure of your health information.
14. APPOINTMENTS: SAASC may use you information to provide appointment reminders by telephone, email or postal service.
15. BUSINESS ASSCOCIATES: We work with other businesses to help SAASC operate successfully. We may disclose your health information to these business associates so that they can perform the tasks we hired them to do. Our business associates must guarantee us that they will respect the confidentially of your personal health information.

_____ II. WHEN SAASC MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATON.

Except as described in the Notice of Privacy Practices, SAASC will not use or disclose your health information without your written authorization.

_____ III. YOUR HEALTH INFORMATION

1. You have the right to request restrictions on certain uses and disclosures of your health information. SAASC is not required to agree to the restrictions that you request.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Request must be made in writing detailing the alternative methods chosen and could be applicable to fees.
3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.
4. You have the right to request that SAASC amend your health information that is incorrect or incomplete. SAASC is not required to change your health information and will provide you information about the denial process.

5. You have the right to receive an accounting or disclosure of your health information made by SAASC except that SAASC does not have to account for the disclosure described in treatment, payment, healthcare operation, and government functions of section I of this notice. The first accounting of disclosers within a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.
6. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
7. . You have a right to obtain a paper copy of this notice upon arrival.
8. You have the right to be notified in the event of a breach in SAASC's patient information.
9. You have the right to request that your health plan not be informed of your treatment at SAASC if you pa in full and your insurance company is not billed.

To answe r any special needs you may have and to assure your patient information is kept confidential, please answer the following questions:
Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one YES NO

If so, please list the names below for our record.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

SAASC reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, SAASC is required by law to comply with this notice. A paper copy of this notice is available if you request a copy.

V. COMPLAINTS

If you believe that your privacy rights have been violated or if you have compla ints about this Notice of Privacy Practices, you may contact any of the following:

1. Complaints and grievances: Department of Community Health
   2 Peachtree Street, NW
   Atlanta, GA 30303-3142
   1(800) 878-6442
2. . South Atlanta Ambulatory Surgical Center: Office Manager
   830 Eagles Landing Parkway Suite 101
   Stockbridge, GA 30281-7366
   Office:(678) 831-4500 Fax: (678) 289-2550
3. Complaints against Physicians: Georgia Composite Medical Board Enforcement Unit
   2 Peachtree St.,35th Floor, Atlanta GA 30303
   Office: (404) 657-6494 Fax: (404) 463-6333
4. Complaints against Nursing Staff:Professional Licensing Boards Division
   Georgia Board of Nursing
   237 Coliseum Drive, Macon GA
   (478) 207-1640

5. Issues regarding Medicare: www.cms.hhs .gov/center/ombudsman .asp

If you are not satisfied with the manner in which SAASC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Service, Office for Civil Rights.
You will not be retaliated against for filing a complaint.

Patient/Representative Signature

Date

SOUTH ATLANTA AMBULATORY SURGICAL CENTER

Financial Policies

South Atlanta Ambulatory Surgical Center is committed to meeting the healthcare needs of all patients in a state of the art environment, with first rate staff and excellence in patient satisfaction. SAASC may not be a participating provider with all insurance plans, but we strive to give patients and insurers the best possible value for their healthcare dollar, providing access to superior quality care to all patients in the community, regardless of insurance type, at a cost-effective rate. Financial responsibility for patients and insurers will be calculated in accordance with any existing contractual agreements in effect on the date of service, pursuant to an assignment of benefits provided by the patient. In the absence of applicable contractual rates*, such as services rendered to patients holding insurance coverage for which the surgery center is not a participating provider, the following policies will apply.

**Contractual rates include, but are not limited to, government set fee schedules for Medicare, Medicaid, TriCare, Worker's Compensation, other government mandated fees, Third Party Agreements, direct employer or patient agreements, and Managed Care contracts.*

1. The surgery center bills both patients and health plans using the same fee schedule.
2. The surgery center requests a deposit on the date of service, which will be applied to the patient's total financial responsibility.
3. Patient responsibility is determined based on the applicable patient portion of contractual rates, where a contractual agreement exists with the payer. Where contractual rates do not apply, surgery center will bill the patient for their financial portion once the claim has been processed, and appealed if necessary, and the allowable has been determined by the insurance company.
4. Upon registration, patients will sign the relevant financial documents, including the Assignment of Benefits, Authorizations & Disclosures and Acknowledgement of Financial Policies.
5. The surgery center will not waive any unmet coinsurance, deductibles or other patient responsibility associated with services for which it has billed a health plan pursuant to an assignment, except for reasons of financial hardship.
6. The surgery center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received, reviewed and processed by the insurance carrier.
7. Verification of benefits is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan in effect at the time of service. Financial obligation is based on applicable benefit levels associated with the services the surgery center provides.
8. When a health plan denies some or all of the charges, the surgery center will pursue the internal appeals process provided by the health plan, and patient responsibility will be billed after the appeal.
9. Final patient responsibility is determined based on the allowed amount of the claim as listed on the insurance company Explanation of Benefits, once processed by the insurance carrier, and the patient's applicable benefit levels.
10. **Patients are informed that estimates of financial responsibility are subject to change based on procedures performed or determination of coverage, and that they remain financially obligated for any and all charges associated with services rendered.**
11. Patients with no insurance coverage will be considered self-pay, and will be eligible for the 70% prompt pay discount off charges.
12. Written estimates of anticipated charges and associated financial responsibility are available upon request.
13. When patients receive payment directly from the health plan, patients must endorse and forward the payment and Explanation of Benefits to SAASC within 5 days of receipt to avoid additional financial liability.
14. Insurance carriers are made aware of the surgery center's discount policy through disclosure on the claim form submitted to the insurer for services rendered. Detailed financial policies are available to the insurer upon request.

Patient Signature Date