

## **USF Health Endoscopy and Surgery Center Patient Agreement and Consent**

1. **CHOICE IN HEALTHCARE FACILITIES:** You have healthcare choices. These are a few alternative facilities available to you:

**University Community Hospital**  
3100 East Fletcher Ave.  
Tampa, Fl 33613  
(813) 971-6000

**Tampa General Hospital**  
2 Columbia Dr.  
Tampa, Fl 33606  
(813) 844-7481

**St. Joseph's Hospital**  
3001 W. Dr. MLK Jr. Blvd.  
Tampa, Fl 33607  
(813) 870-4000

2. **CONSENT TO TREATMENT:** I hereby authorize the physician in charge of my care the Surgery Center to provide services including, but not limited to, emergency medical services, routine, diagnostic procedures, and medical procedures as their judgment may deem necessary or advisable. I acknowledge that any physicians and surgeons furnishing services to me including, but not limited to, radiologists, anesthesiologists, and pathologists are independent contractors with me and are not employees, agents or servants of the Surgery Center. I further understand that I am under the care and supervision of my surgeon and that it is my surgeon's sole responsibility to obtain my informed consent when required for medical, surgical, diagnostic, or therapeutic procedures, or facility services rendered to me under the general or special instructions of my surgeon.
3. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I hereby authorize the Surgery Center and/or any treating physicians, and my insurance company to obtain, or my attorney, use and/or release information (current and historical) for the purposes of treatment, payment, and/or operations, as outlined in the Notice of Privacy Practices. This may include collection agencies, credit bureaus, and myself, and will be limited to the minimum amount necessary.
4. **MEDICARE/ MEDIGAP/ MEDICAID PATIENT CERTIFICATION/ RELEASE OF INFORMATION AND PAYMENT REQUEST:** I certify that the information given to apply for payment under Title XVIII and/or Title XIX, 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. 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, Medigap or Medicaid for payment. I understand that I am responsible for any health insurance deductibles and co-payments.

5. **ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF PAYMENT:** I hereby authorize, request and direct any and all assigned insurance companies to pay directly to the Surgery Center and/or my treating physician the amount due me in my pending claims for facility benefits under the respective policies. For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay the Surgery Center and any treating physicians, all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge. Unpaid accounts shall bear interest at the rate provided by law, whether suit is brought or appeal taken. If any action at law or in equity is brought to enforce this agreement, the facility and/or treating physicians shall be entitled to recover attorney's fees, court costs, and any other costs of collection incurred.

9. **RELEASE OF RESPONSIBILITY AND LIABILITY FOR PERSONAL VALUABLES:** I understand that the Surgery Center discourages retaining personal valuables while at the center and agree that the Surgery Center is not responsible for valuables or belongings brought into the facility. Personal valuables or belongings include, but are not limited to, clothing, dentures, glasses, prosthetic devices (such as hearing aides, artificial limbs, or assist devices such as: canes, walkers, or wheelchairs), credit cards, jewelry and money.

**10. PLEASE INDICATE THE CORRECT ANSWERS BELOW:**

- 1 Are you currently receiving Medicare Benefits? (If yes, answer 2, 3, & 4)  
 Yes  No
- 2 Are either you or your spouse currently working?  
 Yes  No
- 3 Are either you or your spouse currently provided with any group health coverage?  
 Yes  No
- 4 Are you currently receiving any other health care benefits (i.e. Black Lung, Veterans Affairs, government program research grant, work, non-work, or automobile accident related injury or illness benefits)?  
 Yes  No

**I CERTIFY THAT THE INFORMATION CONTAINED IN THIS DOCUMENT HAS BEEN READ BY OR EXPLAINED TO ME AND I UNDERSTAND THIS INFORMATION. I WILL RECEIVE A COPY OF THIS DOCUMENT UPON REQUEST. I ACKNOWLEDGE THAT A COPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient's Authorized Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Surgery Center Representative: \_\_\_\_\_