DISC SURGERY CENTER AT NEWPORT BEACH
Surgical Center Demographics

DATE	LAST NAME	FIRST NAME	M.I.	PHYSICIAN NAME	PATIENT NUMBER

M/F	D.O.B.	AGE	M S W	SSN	HOME #	CELL #	WORK #

ADDRESS: STREET	CITY	STATE	ZIP CODE

EMAIL ADDRESS:

EMPLOYER	HR CONTACT	PHONE #	EMPLOYER ADDRESS

EMERGENCY CONTACT	EMERGENCY CONTACT PHONE	EMERGENCY CONTACT RELATION

PRIMARY INS.CO.NAME		SECONDARY INS.CO.NAME	
INS.CO. ADDRESS		INS.CO. ADDRESS	
ID# / CLAIM#	GROUP#	ID# / CLAIM#	GROUP#

SUBSCRIBER NAME (IF DIFFERENT FROM ABOVE)	SUBSCRIBER D.O.B.	SUBSCRIBER PHONE#	SUBSCRIBER SSN

CLAIM NUMBER	ADJUSTOR NAME	ADJUSTOR PHONE#	D.O.I.

DIAGNOSIS

PROPOSED SURGERY (LINE 1)

PROPOSED SURGERY (LINE 2)

PAYMENT REQUIRED	AMOUNT PAID	BALANCE DUE	RECEIPT

CONSENT TO DRAW BLOOD/EMERGENCY PROCEDURES

I hereby consent to the withdrawal of a blood sample in the event an employee or contractor of the Surgery Center has a needle stick or mucous membrane exposure to my blood or body fluids. I further consent to a medical treatment from a licensed physician in the event of a highly emergent or emergency event in which the patient, a family member or other responsible party cannot reasonably be reached to authorize treatment.

RELEASE OF INFORMATION

In general, the Surgery Center, its personnel and members of its Medical Staff treat medical information concerning the patient's procedure as confidential. I authorize the Surgery Center to release any information necessary for the purpose of determining coverage to my insurer or other entity responsible for claims payments without my further written consent.

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FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

In consideration for the services rendered to the above-named patient, the undersigned hereby individually obligates himself/herself to the account of the Surgery Center in accordance with the Surgery Center's regular rates and terms regardless of whether insurance payments are available or made on my behalf. In the event it should be necessary to refer the account to any attorney or collection agency for collection, I hereby agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts, at the Surgery Center's option, will bear interest at the legal rate.

In consideration of services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits to the above-named Surgery Center otherwise payable to me for this admission. I transfer and assign all rights, title and interest in the above-named insurance policy any payment due me to the above-named Surgery Center. I understand and agree that I am responsible for providing any information required by my insurance company and agree to follow those pre-admission and pre-authorization guidelines, which the insurance company may require. I understand that I am financially responsible for all charges which are not covered by insurance, including but not limited to, co-pays, deductibles, and charges in excess of policy coverage, and limitations or exclusive of coverage.

PERSONAL VALUABLES AND MEDICATIONS

It is understood and agreed that the Surgery Center will not be liable for any loss or damages to valuables, including but not limited to, money, jewelry, glasses, dentures, for items, documents, canes or personal medical equipment or supplies, clothing, shoes or other apparel. It is understood and agreed that I will not bring or consume personal medications without the Surgery Center's notice of written permission from my attending physician and that the Surgery Center will not be liable for any harm incurred thereby.

ADVANCE HEALTHCARE DIRECTIVES

I understand that the Surgery Center has not consented to honor an Advance Healthcare Directive and will not be liable for its terms. Upon my request, the Surgery Center will provide information to me regarding alternate facilities that I may use.

_____ I understand that I am not required to have an Advanced Healthcare Directive in order to receive medical treatment in this Surgery Center

_____ I have not executed an Advance Healthcare Directive.

_____ I understand that I will be resuscitated and transferred to a hospital where my Advance Healthcare Directive and/or DNR may be honored.

PHYSICIAN

In consideration of medical or surgical services rendered to the above-named patient, the undersigned hereby authorizes direct payment of any insurance benefits due to me, to the physician named above, as well as, if required, the Assistant Physician and/or Anesthesiologist . I transfer all rights, title, and interest in the above-named insurance policy, any payment due for physician medical/surgical services to:

Physician _____ Assistant Physician _____

Anesthesia _____

Your physician may or may not be an investor in the Surgery Center. Please contact your physician if you desire further information. Diagnostic and Interventional Surgical Center's Staff will provide you with a complete list of the physician owners of this facility upon request.

I certify that I have read the foregoing and that I am either the patient, parent, legal guardian, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

I understand and agree that, at the time the patient has met the Surgery Center's medical criteria to leave the Center, I will have a responsible adult present to take me/the patient home if I (he/she) have (has) received anesthesia/sedation. I release the Surgery Center from any responsibility for events in violation of this agreement.

_____	_____	_____	_____AM/PM
Patient Signature	Witness Signature	Date	Time

_____	_____
Patient Representative	Relationship to Patient