Waverley Surgery Center
400 Forest Avenue
Palo Alto, CA 94301-2608

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's and/or anesthesia charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center, physician's office, anesthesia and/or pathology providers are not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. If your insurance carrier determines the services are not a covered benefit you are responsible for payment of these services. Self-pay patients are expected to pay the agreed upon balance at the time of service. I am aware that I may receive a separate bill should there be any pathology performed from the pathology companies.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to **Waverley Surgery Center**, my admitting physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at **Waverley Surgery Center** may have an ownership interest in **Waverley Surgery Center**. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at **Waverley Surgery Center**.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my demographic and insurance information on this date and verify that all information reported to the center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ _____
Signature of Patient or Responsible Party Print Name

Relationship to Patient: _____

☐ Self ☐ Parent/Legal Guardian Date Signed

☐ Other: _____

EMAIL/TEXT/AUTOMATED COMMUNICATION INFORMED CONSENT

I hereby consent and authorize **Waverley Surgery Center**, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Patient Signature Date Signed Printed Name

Parent/Guardian Signature (if patient is a minor) Date Signed Printed Name

Contact Information:
☐ Contact Information on file
OR
☐ Alternate Mobile Phone Number: _____ Alternate Email address: _____

To revoke your consent to receive text messages or electronic mail from **Waverley Surgery Center**, you may unsubscribe by replying and entering "Unsubscribe." If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone.