Patient Acknowledgment Form

I, _____ , acting as a (circle appropriate designation) patient, patient's representative, relative, do hereby acknowledge that I received, reviewed and had the opportunity to ask any questions about the following documents:

* Patient Rights and Responsibilities
* Information on Advance Directives
* Disclosure of Financial Interest in the facility
* Notice of Privacy Practices

Designation Statement

I, _____ , designate the following person to be able to speak to a physician or Surgery Center South staff, should it be necessary, on my behalf. I hereby give permission to Surgery Center South through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release Surgery Center South, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____

Relationship: _____ Phone Number: _____ (home /work)
Patient's Name: _____

Patient's Signature: _____

Date: _____ Witness: _____

☐ **I decline to designate another person to speak with my physician or surgery Center South staff.**

Ethnicity: _____ Race: _____

I further do here by acknowledge that the Patient Rights and Responsibilities and Surgery Center South's policies regarding advance directives were verbally explained to me by a representative of this facility to my satisfaction.

I further attest that I have informed Surgery Center South of the existence, if any, of instructions pertaining to advance directives, living wills, DNR order, health care proxies or other forms of expression of patient self-determination.

I have an advance directive: ☐ NO ☐ YES Type: _____

I ( ) have provided or ( ) will provide a copy of any duly executed instrument and acknowledge that said copy will become a part of my medical record.

I understand and acknowledge that it is the responsibility of the patient, or his/her representative, to inform Surgery Center South immediately of any change in the conditions of the above-mentioned expression of patient self-determination.

_____ _____
Print Patient's Name Signature of Patient, Representative, Relative
(Circle appropriate designation)

_____ _____
Date Witness (Signature/Title)

MEDICARE

PART B

EXTENDED PATIENT SIGNATURE AUTHORIZATION

To Be Completed by Providers of Service **Please** print or type

Provider's Name*	Provider's I.D. Code
Surgery Center South	**55049**

Provider's Address (Street, City, State, Zip)

2800 Ross Clark Circle, Suite 3 Dothan, AL 36301-2040

Beneficiary's Name	Health Insurance Number

Payments for Services rendered is to be made as follows

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Anesthesia Group and Surgery Center South (the Supplier) for any services or items furnished me by that physician or supplier. 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."

X _____ _____

Signature of Beneficiary or person signing for Beneficiary — Date signed

Address of person signing for Beneficiary (Street, City, State, Zip) — Relationship

Reason Beneficiary is unable to sign

In submitting claims under this procedure. PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment - **even those in which the physician has not accepted assignment.**
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients. **"DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF.** "This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

In submitting claims under this procedure. SUPPLIERS agree to:

1. Only use the extended patient signature authorization for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement:
   "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED"

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNMENT CASES.

***FOR SUPPLIERS OF DURABLE MEDICARE EQUIPMENT ONLY:**

"This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of or the end of need for the rental of equipment, or the death or instituionalization of the Beneficary."

_____ _____

Signature of Supplier — Date Signed

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East, Birmingham, Alabama 35298

C1320-MEDICARE1
Rev 5/3/16

SURGERY CENTER SOUTH

ASSIGNMENT of Insurance Benefits:

In the event that the undersigned and/or patient is entitled to benefits of any type whatsoever arising out of any insurance policy, worker's compensation or any other party liable to the patient, such benefits are hereby assigned to Surgery Center South for application to the patient's bill. It is agreed that Surgery Center South may receive for such payment and will discharge the said insurance company of all obligations under the policy to the extent of such payment.

The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

Date _____ 20_____ X_____

Patient

_____

Patient's Agent or Representative

_____

Relationship to Patient

Surgery Center South

Medication Reconciliation Form

ALLERGIES: ☐ **No Known Allergies**

	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:
	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:
	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:
	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:
	☐ Rash ☐ Itch ☐ Nausea/Vomiting ☐ Flushing ☐ Anaphylaxis ☐ Other:

Home Medication List: ☐ **Listed by patient** ☐ **MD office list** ☐ **List from pharmacy** ☐ **Bottles** ☐ **Other**

HOME MEDICATIONS Prescriptions, OTCs, Herbals, and Vitamin Supplements, etc.	**Dose**	**Freq**	**Last Dose**	**Take @ home After Discharge**	**DO NOT Take at home after discharge**
		☐ Daily	☐ Today	☐	☐
		☐ Daily	☐ Today	☐	☐
		☐ Daily	☐ Today	☐	☐
		☐ Daily	☐ Today	☐	☐
		☐ Daily	☐ Today	☐	☐
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		☐ Daily	☐ Today	☐	☐
		☐ Daily	☐ Today	☐	☐
		☐ Daily	☐ Today	☐	☐

MEDICATIONS LISTED BY:_____ **DATE**_____

ADDED, DELETED OR CHANGED MEDICATIONS POSTOPERATIVELY **Noted medication, dose, route, frequency**
☐ Prescription given
☐ Prescription given
☐ Prescription given
☐ NA no prescriptions given/no changes noted

RECONCILIATION PHYSICIAN SIGNATURE _____ **DATE**_____

DISCHARGE NURSING SIGNATURE _____ **DATE**_____