FASC General Consent for Treatment

Consent for Examination and Treatment

I have come to the Outpatient Hospital Center to get medical treatment. I freely consent to whatever examination and treatment my physician thinks I need, including but not limited to medical, surgical, laboratory, and x-ray services. I understand that the doctors who provide services to me are not employed by the hospital (surgery center) but are independent contractors who are permitted to use the hospital's facilities to care for and treat their patients.

Patient Rights, Grievance Process and Advanced Directives

I have received a copy of my rights and responsibilities as a patient and understand that the Center has a process to address and resolve any concerns, complaints or grievances. I may call the Administrator to assist me in addressing and resolving these issues. I understand that under Virginia law, I have the right to choose in advance, someone to determine for me what kind of medical treatment I would want should I become incapable of communicating to my doctor what kind of treatment I want. I acknowledge that the Center has available to me "Your Right to Decide" regarding these "Advance Directives." If I already have an Advance Directive, I will provide a copy to be placed in my medical record and I understand that the Center cannot follow the directive of my Advance Directive until I do provide it or draft a new one. If I do not already have an Advance Directive, I may contact one of the pre-operative nurses to discuss one.

Students

I understand that the Center does participate in healthcare education programs. I agree that students may participate in my care.

Deemed Consent

I understand that under Virginia law, if while examining me, any person employed by or under the direction and control of the Hospital or any other healthcare provider is exposed to my body fluid in a manner which may transmit HIV, Hepatitis B or Hepatitis C, I will be deemed to have consented to testing for HIV, Hepatitis B or Hepatitis C infection and to the release of the test results to the exposed person.

Release of Information

I authorize the Center to disclose all or any part of my medical record or other information to any person or entity in accordance with and for purposes permitted by federal and state law, including but not limited to infectious disease reporting and peer review. I also authorize the release of information to the treating physician and to any physician(s) or healthcare facility to which I may be referred or transferred. I authorize the release of information to prospective or actual agencies that may need this information to determine if they can provide services to me.

Personal Valuables/Possessions

I understand that FASC does not have a safe for the keeping of a patient's money or valuables. It is recommended that I leave money and valuables at home. I accept responsibility for any possessions kept by me, including but not limited to dentures, glasses, contact lenses, hearing aids, jewelry, wallets and electronic devices.

Certification

I certify that I have read this entire form, that I was given a chance to ask questions about the form, that any questions about the form have been answered and that I understand the content and purpose of the form. I certify that I am the patient or that I am a person authorized by the patient and/or in accordance with Virginia law, to sign this form and accept its terms.

Acknowledgement Use and Disclosure of Protected Health Information

I understand that Fredericksburg Ambulatory Surgery Center may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered or have received in the past a copy of the Notice of Privacy Practices for Mary Washington Healthcare, which provides information about how the Mary Washington Healthcare facilities (including Fredericksburg Ambulatory Surgery Center) and individuals involved in my care at MWHC facilities, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of my current Notice, please contact the Privacy Officer @ 540.741.1821

Financial Information for Patients

Patient: _____Date of Surgery: _____
Proposed Surgery: _____

Fredericksburg Ambulatory Surgery Center (FASC) fees DO NOT INCLUDE: laboratory or radiography studies, surgeon's fees, anesthesiologist fees, radiologist fees or pathology fees. These services, if provided, will be billed separately by the physician or provider who performs the service.

FASC fees DO INCLUDE the following: use of surgical suites and supplies, recovery room, post-operative observation, anesthesia supplies and medications given while in the center. Implants *may* be priced separately.

If you have insurance that covers your surgery, a claim will be filed with your insurance company for reimbursement. You can expect to receive a monthly statement that reflects any outstanding balance due. Any questions you have concerning your bill post-surgery should be directed to:

MWH billing department (540) 741-1041
AND/OR contact your insurance carrier directly

Most insurance companies encourage ambulatory surgery for its cost effectiveness. It is the responsibility of our patients to confirm with their insurance company their plan participation at FASC and any pre-certification and/or second opinion requirements.

If you do not have insurance or your insurance will not cover the charges, you are expected to make payment arrangements prior to your surgery date. Reach out to MWH Financial Assistance Dept. at (540) 741-1041.

INSURANCE AUTHORIZATIONS: I hereby authorize Fredericksburg Ambulatory Surgery Center to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment of benefits to be made directly to Fredericksburg Ambulatory Surgery Center otherwise payable to me. I understand that I am financially responsible for charges arising for treatment of patient name above. I understand that my insurance will be filed, however, if the insurance company payment is not timely, it is my responsibility to pay Fredericksburg Ambulatory Surgery Center and pursue reimbursement from my insurance carrier. I understand that in the event my account is turned over to an attorney for collection, I shall be responsible for additional attorney fees and court costs. A photocopy of this authorization shall be considered as valid as the original.

MEDICARE PATIENTS: I certify that the information given to me in applying for payment under title XVIII 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 for this or a related Medicare claim. I assign the benefits payable for services to the Fredericksburg Ambulatory Surgery Center. I understand that Medicare will pay 80% of their usual and customary fee and that I am responsible for the remaining 20% of the usual and customary fee in addition to any deductibles.