Clifton Surgery Center
1117 Route 46 East, Suite 303. Clifton ,NJ 07013
Phone: 973-779-7210
Fax: 973-779-7387

Authorization to Release Information and Pay Facility/Anesthesiologist Directly

1. I authorize Clifton Surgery Center to release to appropriate third parties such information as may be necessary, including my diagnosis and other information from my medical records for the purpose of processing my facility and/or anesthesia claim(s) ('bills").
2. I authorize all health insurance payments for services rendered to be sent directly to CSC and/or the Anesthesiologist. These amounts shall not exceed the balance of the facility and/or anesthesiologist's charges for these services. This is a direct assignment of my insurance policy.
3. I understand that I am financially responsible to CSC and/or the Anesthesiologist for all charges not covered by insurance. I understand that I or my insurance company may receive more than one charge originating from different sources for this procedure. For example, separate fees may originate in addition to the physician's fee and will be billed separately (i.e. anesthesiology, facility, laboratory and radiology fees).
4. I acknowledge that the insurance information that I have provided is accurate and true.
5. I understand that in the event of an emergency or the need for extended care, I may be transferred to a hospital or may need to seek treatment at an Emergency Room within 24 hours after having my procedure performed. In either case, I authorize CSC to obtain a copy of my "Discharge Summary" so as to provide the Center with appropriate follow-up information.
6. I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct and I authorize CSC and/or the Anesthesiologist to release to the Medicare Bureau, CMS, and/or its intermediaries or carriers any information about me needed for this claim including any medical information relating to my treatment.
7. I understand that I should not bring any valuables to CSC and that the Center is not liable for theft or loss of any valuables.
8. I understand if the physician who is rendering services has an ownership in Clifton Surgery Center, that I have the option to be treated at another facility. I wish to be treated at the above referenced facility.
9. A copy of the Patient's Rights and Responsibilities has been offered to me or to my representative.
10. A copy of the HIPPA Notice of Privacy for CSC has been offered to me or to my representative.
11. I understand that with the exception of local anesthesia, a responsible adult must be present to drive me home from the Center after surgery. I also acknowledge that I have a responsible adult, whose care I will be under for the next 24 hours.

ADVANCE DIRECTIVES WAIVER: I have previously executed an Advance Directive: ☐ Yes ☐ No

Should you need information on Advance Directive please visit the following website:
http://www.state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf

If you answered "Yes", read the following important information:

12. Some of the procedures and medications used during your surgery could be similar to procedures and medications specified in Advance Directives during your admission to the Center. Therefore to insure the best possible care during your surgery you MUST waive your Advance Directives during your surgical admission at the center.
13. I acknowledge that all resuscitative measures will be taken during my stay at the Center, and I further understand that if I have ever signed an Advance Directive, **I temporarily waive it in its entirety for the duration of my visit at *Clifton Surgery Center.***
14. I acknowledge that I was provided information on Patient's Rights, Advance Directive's and my physician's financial interest in CSC 24 hours in advance of my admission to the surgery center as per the requirements of Conditions for Coverage by the Federal Medicare Program
15. I acknowledge that I was provided with Clifton Sugery Center's COVID-19 testing requirements prior to the date of my procedure and I attest that I followed the requirements of wearing a mask or face covering, social quarantining, and social distancing, as well as adhered to the notification requirements therein.

By signing here, I agree to all fifteen (15) authorizations on this page.

✖ Patient Signature	Parent/Guardian/Representative(If patient is unable to sign)	Date
✖ Printed Name	Printed Name/Relationship	Witness