VAIL VALLEY SURGERY CENTER
EDWARDS

CONDITIONS OF ADMISSION
TO
VAIL VALLEY SURGERY CENTER EDWARDS
(THE "SURGERY CENTER")

CONSENT TO MEDICAL, SURGICAL PROCEDURES: I request and consent to the medical care and diagnostic procedures that my attending physician, surgeon or his/her designee, determines are necessary, including but not limited to, emergency treatment or services, laboratory procedures, x-ray examination, medical or surgical treatment, anesthesia, transfusion, physical therapy, rehabilitation services. I acknowledge that the medical care I receive while in the Surgery Center is under the direction of my attending physician(s) and the Surgery Center is not responsible for acts or omissions of my attending physician(s) or surgeon(s).

UNBORN CHILD COVERAGE: If pregnant, the above consent for treatment, releases, assignments, and guarantor agreement apply to my newborn child if born at this Surgery Center during this period of treatment.

GENERAL NURSING CARE: I acknowledge that the Surgery Center provides only general nursing care. If I need special or private nursing, I have been advised it must be arranged by me or my physician.

MONEY AND VALUABLES: I have been informed and understand that the Surgery Center does not assume any responsibility for any money, valuables or other personal property that I choose to keep with me.

VIDEO CONSENT: I consent and authorize my physician or surgeon to film or video tape my surgical procedure(s). I understand the purpose is to "provide a visual record of portions of my surgery and a method for my surgeon to review with me what was done while I was under anesthesia." I also consent to the use of said video for research and/or testing purposes.

DISCLOSURE OF INFORMATION: The undersigned agrees that records concerning their medical services at the Surgery Center will remain the property of the Surgery Center. The undersigned understands that medical records and billing information generated or maintained by the Surgery Center are accessible to Surgery Center personnel and medical staff. Surgery Center personnel and medical staff may use and disclose medical information for treatment, payment and health care operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The Surgery Center is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of the patient's account. The undersigned understands that the authorization for release may include records, which may indicate the presence of a communicable, or venereal disease, which include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Symptoms (AIDS).

PAYMENT FOR MEDICAL CARE: I agree that in consideration for the medical care I receive from the Surgery Center, its employees, agents, designees, or independent contractors, I guarantee and promise full payment for all charges by the Surgery Center or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party payor (for example, an insurance carrier or health maintenance organization (HMO) with which the Surgery Center has specifically entered into an agreement for payment of medical care provided by the Surgery Center or by its employees, agents, designees or independent contractors). The undersigned agrees to be financially responsible for any services deemed non-covered by insurance or elected by the patient. Should the account be referred to any attorney or collection agency for collection, the undersigned shall pay all actual attorneys' fees and collection expenses. All delinquent accounts may bear the highest interest rate permitted by law.

ASSIGNMENT OF BENEFITS: I hereby authorize and assign payment to the Surgery Center of any type of reimbursement or payment from Medicare or State Medicaid programs or other third party payor, for any and all cost of my medical care provided at the Surgery Center or by its agents, designees, or independent medical contractors. Further, I understand that Anesthesiology, Physician Services, Pathology and some Laboratory Services may bill me separately and I assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim. I understand that Precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

I have been informed that my physician or surgeon may be a partner in ownership of the Surgery Center and that I have the right to review a list of partners. The physicians, surgeons and allied health professionals (AHPs) practicing at the Surgery Center are licensed and/or credentialed to practice at the Surgery Center. The physicians, surgeons and AHPs provide medical services at the Surgery Center but are not agents or employees of the Surgery Center.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

Signature of Patient, Parent, Legal Guardian, Representative		Date/Time	Please Print Name of Patient, Parent, Guardian
Signature of Guarantor	Relationship to Patient	Date/Time	Please Print Name of Guarantor
Signature of Witness		Date/Time	Please Print Name of Witness