THE KNOXVILLE EYE SURGERY CENTER, LLC TENNESSEE VALLEY EYE CENTER
140 Capital Drive, Suite 2, Knoxville, Tennessee 37922

GENERAL CONSENT TO ADMISSION, MEDICAL TREATMENT AND RELEASE OF INFORMATION

CONSENT FOR TREATMENT: Authorization is hereby given to the Knoxville Eye Surgery Center, LLC to perform such treatments, services, procedures, diagnostic studies, nursing care, surgery, invasive procedures and medical treatment that my attending physician and/or his/her designee consider to be necessary. I understand that medicine is not an exact science and that diagnosis and treatment may involve risk of injury or even death. I acknowledge that no guarantees have been made to me regarding the outcome of this treatment. I understand that I have the right to accept or refuse consent of any proposed procedure or therapeutic course, and that I will not be involved in any research or experimental procedure without my knowledge and consent. Obtaining consent for special procedures and treatments is the responsibility of my physician.

ADVANCED DIRECTIVES: I understand that any Advanced Directive including a "Do Not Resuscitate" (DNR) order will be suspended while a patient at this ambulatory surgery center. All patients will be resuscitated and transferred to a hospital. I have the right to discuss this in advance with my surgeon if I do not wish to receive this emergency treatment in order to make special arrangements.

COPY PROVIDED BY PATIENT: ☐ YES ☐ NO

RELEASE OF INFORMATION: I authorize the Knoxville Eye Surgery Center, LLC and or my attending physicians to disclose any and all information in my medical record to any person, insurance company or other party which is or may be liable for all or part of the charges associated with this service. I further authorize the Knoxville Eye Surgery Center, LLC to furnish information contained in my medical record to other healthcare providers in order to facilitate my continued care and treatment. The Knoxville Eye Surgery Center, LLC is authorized to release this information even though the confidentiality of the information may be protected by Federal or State laws and regulations. The Knoxville Eye Surgery Center, LLC, its agents and employees, are hereby relieved of any liability that may arise from the release or reproduction of such records or information.

FINANCIAL AGREEMENT: For and in consideration of all services rendered by the Knoxville Eye Surgery Center, LLC I understand that I am responsible for the payment of any and all charges for services rendered which are not covered by Medicare, Medicaid, TennCare, private insurance or other third party payor. I accept responsibility for any services deemed medically unnecessary by any third party payor. I understand that if more than one person signs this agreement their liability shall be joining and several. If I or my insurance fail to make

payment for these services when due, the center may at any time, without notice or demand, declare the entire unpaid balance to be immediately due and payable. I further agree to pay reasonable attorney and collection fees if this account is placed for collection. I authorize and direct my insurance company to pay directly to Knoxville Eye Surgery Center, LLC any and all benefits up to the amount of my bill. I understand that all medical transportation costs, emergency room costs or hospital costs incurred due to medical necessity, physician services, including specifically services of radiologists, pathologists, and anesthesiologists, attending physicians and others will be billed independently by the provider of services and I accept responsibility for paying such charges and hereby grant assignment of insurance benefits for this service.

MEDICARE AND MEDICAID PATIENT CERTIFICATION/ INFORMATION: I certify that information given by me in application for payment under Title XVIII and Title XIX of the Social Security Act and Title XIX Medicaid is correct. I authorize any holder of information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I request payment of benefits be made on my behalf. I, as a Medicare beneficiary, have been informed in writing that the care for which Medicare payment is sought will be subject to review by the Peer Review Organization and some services may be denied as not medically necessary or appropriate. I am aware of my rights and responsibilities.

INFECTION CONTROL: If any employee of the Knoxville Eye Surgery Center, LLC or other health care worker is exposed to my blood or other body fluids, I hereby authorize the Knoxville Eye Surgery Center, LLC to test my blood for Hepatitis B & C and HIV (the virus that causes AIDS). I understand the tests will be done at the expense of the Knoxville Eye Surgery Center, LLC.

I HAVE READ THE ABOVE INFORMATION, AND I CERTIFY AND ACKNOWLEDGE THAT I UNDERSTAND ITS CONTENTS AND SIGNIFICANCE.

_____	_____	_____
Patient or Guardian	Relationship to patient	Date
_____	_____	
Witness	2nd Witness needed for verbal consent	

If patient is unable to execute above form for any reason, such as being a minor, explain: _____

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HIPAA: Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand and have been provided with a Notice of Privacy Policy that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

We will need to use your information to contact you with appointment reminders; do we have your permission to:

Leave message on answering machine? ___ Yes ___ No

Leave message with family member? ___ Yes ___ No

I fully understand and ❑ **accept** ❑ **decline** the terms of this consent.

STATEMENT BILLING: I understand I may receive 3 separate statements (bills) for my surgery in the event the procedure is not completely covered by my insurance. Each billing office is separate.

- 1 statement from your surgeon
- 1 statement from Knoxville Eye Surgery Center
- 1 statement from your anesthesia provider

_____ _____

Patient's Signature Witness Signature

_____

Date

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PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial ___

Billing Address_____ Apt. # _____

City_____ State_____ Zip _____

Please circle: Male / Female Date of Birth:_____ SSN#_____

Preferred Phone# 1st ( )_____ 2nd( )_____ 3rd( )_____

****Race and Ethnicity are required by the state of Tennessee****

Race: Please circle - White, Black or African American, Asian, Native American, Other

Ethnicity: Please circle - Not Hispanic, Hispanic, Hispanic Origin unknown

Marital Status: Please circle: S M W D

Please circle: Retired / Disabled / Unemployed / Employed

Employer Name_____

Spouse Name: _____Please circle-Spouse: Retired / Disabled / Unemployed / Employed

Spouse Employer Name_____ Spouse SSN#_____

Name of Emergency Contact (not living with you) Name_____

Phone# of contact ( )_____ Relationship to Patient_____

Primary Insurance_____ Secondary Insurance_____

*** If you have MEDICARE, Please answer the next 8 questions ***

1) Are you entitled to Medicare based on age ☐Yes ☐No disability ☐Yes ☐No or end stage renal disease? ☐Yes ☐No

2) Do you have another insurance through your own employer? ☐Yes ☐No or a spouses employer? ☐Yes ☐No

3) Are you receiving Black Lung benefits? ☐Yes ☐No 6) Is this treatment due to an accident other than automobile? ☐Yes ☐No

4) Is this treatment a work related accident/condition? ☐Yes ☐No 7) Is treatment due to fault of another party? ☐Yes ☐No

5) Is this treatment due to an automobile accident? ☐Yes ☐No 8) Is this treatment covered under veterans administration? ☐Yes ☐No

Form completed by:_____ _____
Signature/Relationship to patient Date

Patient's transportation home:_____
Name/Phone#

**** If this is transportation service PLEASE notify the receptionist!**

If patient under 18
Name of Responsible Party_____ Phone # ( )_____

Relationship to patient_____ Employer of Responsible Party_____