PREMIER NEUROSURGICAL INSTITUTE | PREMIER AMBULATORY SURGICAL CENTER

Patient Information

Patient's Name: _____ Height: _____Weight: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____ Sex: M_____/F_____

Social Security Number: _____ DOB: _____/_____/_____ Race: _____

Employer's Name: _____ Work Phone Number: _____

Marital Status: (Please **Check**) ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Spouse's Name: _____ DOB: _____/_____/_____

Social Security Number: _____

Spouse's Employer: _____ Spouse's Work Phone Number: _____

Name of Nearest Relative not living with you: _____

Best Contact Phone Number: _____

Name of Family Physician: _____ Phone Number:_____

PRIMARY INSURANCE: _____ Policy Holder: _____

Policy ID #:_____ Group #:_____ Phone:_____

Claim Mailing Address: _____

Secondary Insurance: _____ Policy holder: _____

Policy ID #:_____ Group #:_____ Phone:_____

Claim Mailing Address: _____

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Is your condition a result of an AUTO ACCIDENT? ☐ or **WORKERS COMP**? ☐

Date of Injury: ___/____/_____

Insurance: _____

Policyholder: _____

Policy #:_____Claim/File #:_____ Adjuster: _____

Claims Mailing Address: _____

If you have an ATTORNEY, please provide the complete name(s) and address below:

_____

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

OWNERSHIP

I understand that Dr. Chitale is on staff at Premier Ambulatory Surgery Center providing medical services and is the owner of the facility. I understand that I may choose to have my surgery in a facility that is not owned by Dr. Chitale. I have been given this option and choose to have my surgery at Premier Ambulatory Surgery Center.

RELEASE OF INFORMATION

Premier Ambulatory Surgery Center is hereby authorized to request and/or release any medical records, radiographic or diagnostic imaging results, pertinent to the healthcare of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or another health care provider. I understand that the information released to these facilities will be used in furthering or processing my claim with my insurance company. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by the physician of Premier Ambulatory Surgery Center. I understand that I am entitled to a photocopy of this authorization upon request.

ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of Premier Ambulatory Surgery Center to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If your carrier is out of network, you are expected to pay at time of service, unless arrangements have been made with the financial advocate. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Premier Ambulatory Surgery Center all surgical, medical insurance and/or other benefits, if any, otherwise payable to me for the services. I agree to endorse the check(s) over to Premier Ambulatory Surgery Center. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to Premier Ambulatory Surgery Center from the obligor of said benefits. Further, I hereby assign and convey Premier Ambulatory Surgery Center, unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for Premier Ambulatory Surgery Center any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds. I understand that payment is due when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to Premier Ambulatory Surgery Center. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with Premier Ambulatory Surgery Center be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

PRESCRIPTION POLICY

Prescriptions and refills for medications are issued during office hours only, 7:00 AM to 4:00 PM, Monday through Friday. No medications will be refilled over the phone after hours or on the weekends. If you have an emergency, you will be directed to the emergency department at the local hospital. During the course of treatment with our office, do not obtain pain medications from any other source.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated and reported to the Administrator of Premier Ambulatory Surgery Center. Any substantiated allegation will be reported to the State and/or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within ten (10) days of receipt of the grievance. Contact information for the State of Georgia is included on the Patient Bill of Rights.

ADVANCE DIRECTIVES

Premier Ambulatory Surgery Center treats healthy patients and therefore requires a copy of a patients advanced directives to be presented on admission if the patient wishes them to be honored by the facility transferred to in case of emergency. In the event of a medical emergency or other life threatening situation, resuscitation will be instituted in every instance and patients will be transferred to a higher level of care. I consent to emergency transfer to WellStar Kennestone Hospital in case of the need for emergency hospital care. A copy of the advance directive may be placed on the chart if the patient desires and forwarded to WellStar Kennestone Health System in the event of a transfer. Information regarding advance directives is made available upon the patient's request. The admitting facility is affiliated and in partnership with Premier Ambulatory Surgery Center.

I have been asked if I have advanced directives and understand I may supply them to Premier Ambulatory Surgery Center in the event of a transfer.

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

During my care and treatment, I understand that various types of tests, diagnostic or treatment procedures may be necessary. These procedures may be performed by the physician, nurses, technicians, physician assistants or other health care professionals. While routinely performed without incident, there may be material risks associated with each of these procedures. I consent to any examination, laboratory procedure, anesthesia, medical, surgical or services given to the patient under the general and special instructions of the physician. I consent to healthcare professionals performing routine procedures and treatments which may include needle-sticks for IV's and medications, physical tests, such as obtaining bodily fluids, and insertion of internal tubes such as a catheterization tube. I consent to lab work. If a healthcare worker comes in direct contact with a patient's blood or body fluids, I understand that the patient's blood may be tested for the Hepatitis B virus, Hepatitis C virus and the HIV virus, to determine whether or not the viruses are present, endangering the healthcare worker.

PATIENT RIGHTS

1. Patients are treated with respect, consideration and dignity.
2. Full consideration of patient privacy concerning consultation, examination, treatment and surgery.
3. To have considerate and respectful care, provided in a safe environment.
4. To become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may use an appointed representative.
5. Have a family member or representative of his/her choice be involved in his/her care.
6. Have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient
7. Remain free from seclusion or restraints of any form that are not medically necessary.
8. Coordinate his/her care with physicians and healthcare providers they will see; patients have the right to change their provider if other qualified providers are available.
9. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
10. Patient will receive information about any proposed treatment or procedure as needed to give informed consent or to refuse treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment of non-treatment and the risks involved.
11. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
12. Be informed by physician or designee of the continuing healthcare requirements after discharge.
13. Confidential treatment of all communications, disclosures and records pertaining to patient care; patients will be given the opportunity to approve or refuse their release except when release is required by law.
14. Access his/her medical records within a reasonable time after a request for records is submitted.
15. May leave the facility even against medical advice.
16. Patients are informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations.
17. Upon patient inquiry, patient may receive information regarding the estimated charges for routine office visits, routine treatments, and lab tests before receiving treatment.
18. Exercise these rights without regard to race, sex, cultural, educational or religions background or the source of payment for care.
19. Informed regarding: patient conduct and responsibilities, services available at the surgery center, provisions for after-hours and emergency care, fees for services, payment policies, right to refuse participation in experimental research, advance directives will be accepted at the surgery center, charity and indigent care policy, charges for services not covered by third-party payors, and credentials of health care professionals

****ALL FACILITY PERSONNEL PERFORMING PATIENT CARE ACTIVITIES SHALL OBSERVE THESE ABOVE RIGHTS****

PATIENT RESPONSIBILITIES

The patient has the responsibility for

a. providing complete and accurate information to the best of his/her ability about his/her health (i.e., complaints, past illnesses, hospitalizations, any other health related issues) , any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
b. making it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood.
c. following the treatment plan established by the physician, including instructions by nurses and other health care professionals, given by the physician.
d. Providing a responsible adult to transport him/her from the surgery center and remain with him/her for 24 hours, if required by his/her provider.
e. refusal of treatment and/or not following directions.
f. assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
g. being respectful of all the health care providers and staff, as well as other patients.
h. following facility policies and procedures.
i. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

PATIENT COMPLAINTS

Patients have the right to register a complaint, in writing, to the Administrator of Premier Ambulatory Neuro Surgery Center. Please submit complaint to:

ATTN Vernon Spellman
211 Chicopee Dr., Marietta GA 30060
678.872.8750

If the complaint is not resolved to the patient's satisfaction he/she has a right to file a grievance with the Healthcare Facility Regulation Division, Department of Community Health, Complaints Unit for concerns against the surgery center, the Georgia Composite Medical Board concerning the physician or the Professional Licensing Boards Division, Georgia Board of Nursing with concerns against any of the nursing staff. The patient should either call any of the complaint units or send a written complaint. The patient should provide the physician or surgery center name, and address and the specific nature of the complaint.

COMPLAINTS AGAINST MEDICARE: www.cms.hhs.gov/center/ombudsman.asp 1-800-MEDICARE

COMPLAINTS AGAINST THE ASC:

Healthcare Facility Regulation Division
Department of Community Health
Attn: Complaints Unit
2 Peachtree Street, N.W., Suite 31-447
Atlanta, Georgia 30303-3142
P: (404) 657-5726; P: (404) 657-5728
P: (404) 647-9639
OUTSIDE ATLANTA CALLING AREA
P: (800) 878-6442
ONLINE:https://services.georgia.gov/dhr/reportfiling/searchFacility.do?action=constituentComplaint

COMPLAINTS AGAINST THE PHYSICIAN:

Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303
P: (404) 657-6494; (404) 656-1725
F: (404) 463-6333
MAILED:
http://www2.files.georgia.gov/GCMB/Files/CP%20Form%20022010.pdf
ONLINE:
https://versa.medicalboard.georgia.gov/datamart/gadchComplaint.do?from=loginPage

COMPLAINTS AGAINST NURSING STAFF:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858
P: (478) 207-2440

ONLINE:
https://secure.sos.state.ga.us/myverification/SubmitComplaint.aspx

PREMIER NEUROSURGICAL INSTITUTE | PREMIER AMBULATORY SURGICAL CENTER

ACKNOWLEDGEMENT OF RECEIPT

Date: _____

I acknowledge that I have read Premier Ambulatory Surgical Center's Notice of Privacy Practices and Patient Rights. Your name and signature on this form indicates that you have received a copy on the date and time indicated below.

If you have any questions regarding the information contained in Premier Ambulatory Surgical Center's Notice of Privacy Practices, please contact Premier Ambulatory Surgical Center's Practice Administrator at 678-872-8750.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____ Time Received: _____

FOR FACILITY USE ONLY

We have attempted to obtain written acknowledgement of patient's receipt of our Privacy Practices, but acknowledgment could not be obtained from the patient for the following reasons:

☐ Individual Refused to Sign

☐ Emergency Situation Prevented Signature

☐ Patient Requested Above Individual to Sign on His/Her Behalf

☐ Other (please Specify)

_____

Office Staff Signature: _____ Date:

PREMIER NEUROSURGICAL INSTITUTE | PREMIER AMBULATORY SURGICAL CENTER

SECURITY CAMERA CONSENT

Premier Ambulatory Surgical Center facility is monitored by cameras to increase overall security and safety of our patient population, to prevent crimes and to allow surgery center employees to watch for troubled patients and unauthorized visitors in restricted areas.

I hereby consent to the use of camera at this facility for the above-mentioned reasons only.

_____ _____

Patient Signature Date

PREMIER NEUROSURGICAL INSTITUTE | PREMIER AMBULATORY SURGICAL CENTER

Re:
Assignment of Benefits

Patient Name:	Health Plan ID Number:
Claim Number:	Group Number:
Claim Date:	Insured/Plan Member:

Dear Sir:

As you may know, Georgia law § 33-24-59.3 and § 33-24-54 require health care insurer providers to honor their insureds request to assign payments directly to their health care provider, even if the physician is a non-participating provider. Specifically, O.C.G.A § 33-24-59.3 (b) provides that:

> Any other provision of law to the contrary notwithstanding, if a covered person provides in writing to a health care provider, whether the health care provider is a preferred provider or not, that payment for health care services shall be made solely to the health care provider and to be sent directly to the health care provider by the health care insurer, and the health care provider certifies to same upon filling a claim for the delivery of health care services, the health care insurer shall make payment solely to the health care provider and shall send said payment directly to the health care provider. This subsection shall not be construed to extend coverages or to require payment for services not otherwise covered.

Please direct all payments on behalf of _____, directly to our office, **Premier Ambulatory Surgical Center 211 Chicopee Drive Ste C, Marietta, GA 30060**. For your records our tax ID number is 45-4424511. Please call me if I can be any further assistance.

Sincerely,

_____ _____

Vernon Spellman, Practice Administrator
Premier Ambulatory Surgical Center

Date

PREMIER NEUROSURGICAL INSTITUTE | PREMIER AMBULATORY SURGICAL CENTER

Insurance Authorization and Assignment of Benefits

This document provides for the assignment of benefits from the following patient and the following claim directly to Premier Ambulatory Surgical Center.

Patient Name:	Health Plan ID Number:
Claim Number:	Group Number:
Claim Date:	Insured/Plan Member:

I, _____ herby absolutely authorize Premier Ambulatory Surgical Center to apply for benefits on my behalf for services rendered to me or my dependent(s). I further assign any benefits provided on my behalf for care I have received from Premier Ambulatory Surgical Center to Premier Ambulatory Surgical Center and I request my insurance to make payments directly to Premier Ambulatory Surgical Center. **My insurer should not send payments directly to me for services provided by Premier Ambulatory Surgical Center.** I understand the Premier Ambulatory Surgical Center may be outside of my insurer's network and that this provider may charge higher amounts then I might pay through an in-network provider. I agree to pay any difference.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney for collection or taken to court, I agree to pay any collection fees, reasonable legal fees, court costs, and other expenses incurred as a result of the collection. I agree, that if payment is made from my insurance provider directly to me, that I will immediately inform Premier Ambulatory Surgical Center and that I will immediately deliver the payment to Premier Ambulatory Surgical Center without cashing or depositing the check.

I hereby authorize Premier Ambulatory Surgical Center, the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits.

Furthermore, I permit a copy of this authorization to be used in place of original.

_____ _____

Patient Signature Date

_____ _____

ASC Employee Witness Date

Tara Janos, Front Office Coordinator 211 Chicopee Drive, Marietta, GA, 30060

ASC Employee Name and Address

PREMIER NEUROSURGICAL INSTITUTE | PREMIER AMBULATORY SURGICAL CENTER

Date: _____

I, _____, understand that there are separate charges for any procedures done at Premier Ambulatory Surgical Center. There may be two separate charges for Dr. Chitale and Quentin Jenkins, PA for my date of service at Premier Neurosurgical Institute, which are considered ***professional charges***. ***Facility charges*** for Premier Ambulatory Surgical Center are separate and paid upfront before services are rendered. Surgical procedures requiring anesthesia will be billed through in-network benefits as a separate charge by Georgia Anesthesiologists, PC.

I also understand that my **in-network** benefits for professional charges and **out-of-network** benefits for facility charges will apply and I will be fully responsible for any amounts designated as "patient's responsibility" by my insurance company such as: co-payment, deductibles and co-insurance; for any **professional and facility** charges.

I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility based on benefits obtained through the insurance company. I authorize my insurance benefits be paid directly to Premier Ambulatory Surgical Center.

If you have any questions or concerns at a later date in regards to your bill, feel free to contact the Premier Ambulatory Surgical Center billing department at 678-872-8750 extension *301.

_____

Patient Signature

_____

ASC Employee Signature

PREMIER NEUROSURGICAL INSTITUTE | PREMIER AMBULATORY SURGICAL CENTER

PROVIDER ON BEHALF OF MEMBER APPEAL

I, _____ give Premier Ambulatory Surgical Center authorization to appeal all denied and or unpaid claims on behalf and to receive any information pertaining to the payment of my claim(s).

According to state and federal laws, as a member of this health plan: I have the right to request and expect fair and accurate review and coverage for rendered medical services as they pertain to my benefits. I ask that you accurately apply the terms of my policy to the claim for this date of service and submit prompt payment to the provider of service.

Sincerely,

_____

Patient Signature