

# THE ADVANCED SURGICAL INSTITUTE

8112 Milliken Avenue, Suite 200, Rancho Cucamonga, CA 91730

Phone (714)969-2520 Fax (714)969-7480

## CONDITIONS OF ADMISSION

1. **NURSING CARE:** This center provides only general duty nursing care unless upon orders of the patient's physician the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The center shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.
2. **MEDICAL AND SURGICAL CONSENT:** The patient is under the care and supervision of his/her attending physician and it is the responsibility of the center and its nursing staff to carry out the instructions of such physician; the undersigned recognizes that all physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors and are not employees or agents of the hospital. The undersigned consents to X-ray examination, laboratory procedures, anesthesia, medical or surgical treatment, or hospital services rendered the patient under the general and special instructions of the physician.
3. **RELEASE OF INFORMATION:** To the extent necessary to determine liability for payment and to obtain reimbursement, the center may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the center's charge, including but not limited to, insurance companies, health care service plans or worker's compensation carriers.
4. **PERSONAL VALUABLES:** It is understood and agreed that the center maintains a safe for the safekeeping of money and valuables, and that the center shall not be liable for the loss or damage to any money, jewelry, documents, furs coats, and fur garments or other articles of unusual value and small compass, unless placed therein, and shall not be liable for loss of damage to any other personal property, unless deposited with the hospital for safekeeping.
5. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the center in accordance with the regular rates and terms of the center. Should the account be referred to any attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. AU delinquent accounts shall bear interest at the legal rate.
6. **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned authorizes, whether he/she signs as agent or as a patient, direct payment to the center, of any insurance benefits or Unemployment Compensation Disability otherwise payable to the undersigned for this hospitalization at a rate not to exceed the center's regular charges. It is agreed that payment to the center pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.
7. **HEALTH CARE SERVICE PLANS:** This center maintains a list of the health care service plans with which it has contracted. A list of such plans is available upon request from the financial office. The center has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full cost of all services rendered to him/her by the center if he/she belongs to a plan which does not appear on the above-mentioned list.
8. **PEER REVIEW OF RECORDS PERMISSION:** I, the undersigned authorize The Advanced Surgical Institute to disclose complete information concerning the medical findings and treatment of the undersigned, including all dates of service, to those individuals who, in the Governing Body's opinion are required to receive such information for the purpose of medical treatment, medical quality assurance/improvement and peer review.

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

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Patient/Parent/Guardian

Date

Witness

Date