3801 Ireland Grove Rd | Bloomington, IL 61704 | PH: (309) 664-0101 | FAX: (309) 664-1010

CARE COMMUNICATION FORM

We strive to communicate in a timely and professional manner when it comes to your medical treatment. There are occasions when family members, friends, and/or others may be involved in your care. Please complete this form authorizing Ireland Grove Center for Surgery to discuss your personal health information and discharge instructions for post-op care with the listed individual(s) involved in your care.

Name of individual(s) with you today we may speak to about our medical information and discharge instructions regarding your procedure		
NAME	**RELATIONSHIP**	**PHONE NUMBER**

COMMUNICATION METHODS (Please check the communication method preference):

- ☐ May leave message on my home phone
- ☐ May leave a message on my cell/mobile phone
- ☐ May leave a message on my business phone
- ☐ May **NOT** leave message on any phone

___________________________________ ___________________________________
Patient/Guarantor Signature (if under 18) Print Patient/Guarantor Name

___________________________________ ___________________________________
Guarantor Relation to Patient Date

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CENTER FOR SURGERY
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FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF RECORD(S)

- I understand that the facility and anesthesia providers file for reimbursement from my insurer, Worker's Compensation insurer or other payers as a courtesy, and failure on the insurer to make payment shall not relieve me of my obligation to pay the facility and/or anesthesia provider fees.
- All facility and anesthesia provider charges are due and owing at discharge in consideration of the services rendered. Consideration for the services rendered will be limited to: the extent not expressly prohibited by law, usual and customary charges, or the contractual agreement between the facility or anesthesia providers and my third-party payer. I waive all claims of exemption. I agree, whether I am signing as a patient or guarantor, to pay all sums due to the facility and anesthesia provider at their usual, customary and/or contracted rate (if applicable).
- I hereby assign to and authorize payment directly to Ireland Grove Center for Surgery, LLC, Ambulatory Anesthesiology, LTD and Superior Anesthesia Solutions, LLC all benefits due to me under Medicare, Medicaid, or any insurance policy providing benefits for facility and anesthesia charges for services rendered at the facility. A photo copy of this agreement shall be considered as effective and valid as the original.
- I irrevocably agree that the facility and anesthesia providers may disclose, to the extent allowed by law, my medical and financial record to (a) any affiliate of the facility, specifically including Ireland Grove Center for Surgery and its employees and agents, including entities under contract with same to provide quality and/or utilization review, (b) any person or entity which may be liable under contract or by law to the facility or to me any person or entity responsible for all or part of the facility charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Health Care Financing Administration, any government or accrediting agency, or their agents or employees.
- Should the account be referred to an attorney or collection agency for collection, I shall pay a $25.00 placement fee whether a suite is filed or not. Delinquent accounts may bear interest on the unpaid balance up to the maximum amount allowed by law. If for any reason a payment is returned by your financial institution due to insufficient funds, your account will be assessed a NSF fee not to exceed the amount by law.
- **Accounts are considered delinquent if the balance is not paid-in-full or an approved monthly auto payment plan has not been established with the Ireland Grove Center for Surgery Business Office within 60-days of the first statement date. All payment plans will be facilitated through Ireland Grove Center for Surgery's electronic clearinghouse which will require patients or guarantors to submit either a credit card or bank account information for automatic scheduled monthly withdrawals.**
- **I acknowledge I have read and understand all financial policies of Ireland Grove Center for Surgery. I understand insurance copayments are due at the time of service. I understand I am responsible for prompt payment including copayments, coinsurance and deductible amounts.**

_______________________________________   _______________________________
Patient/Guarantor Signature (if under 18)   Print Patient/Guarantor Name

_______________________________________   _______________________________
Guarantor Relation to Patient   Date

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PATIENT BILL OF RIGHTS AND PATIENT RESPONSIBILITIES

Reasonable, informed participation in decisions involving your health care is your right. The rights of our patients are an important component of our care for you. We respect your rights and request that you recognize your patient responsibilities at Ireland Grove Center for Surgery.

FAILURE TO FULFILL THE FOLLOWING RESPONSIBILITIES IS GROUNDS FOR TERMINATION TO RECEIVE CARE AT IRELAND GROVE CENTER FOR SURGERY. I UNDERSTAND THAT I, AS THE PATIENT/RESPONSIBLE PARTY OF PATIENT, HAVE THE FOLLOWING RESPONSIBILITIES:

1. To be considerate for other patients, staff and visitors at Ireland Grove Center for Surgery
2. To respect the property of others and the property of Ireland Grove Center for Surgery
3. To observe the prescribed rules during your stay and treatment
4. To provide complete, valid and up to date identification and health insurance information.
5. To inform the facility regarding any living will, medical power of attorney, or other directive that could affect care.
6. To ask the medical staff any questions necessary to fully understand treatment
7. To follow and understand the planned course of treatment and expectations regarding the treatment
8. To follow the treatment plan prescribed by my providers and participate in my care
9. To ask the medical staff what to expect regarding pain and a pain management plan
10. To provide medical staff with the most accurate and complete information regarding present complaints, past illness, hospitalizations, medications, unexpected changes in patient conditions or any other patient health concerns
11. To provide a responsible adult caregiver to transport me home from Ireland Grove Center for Surgery **and remain with me for twenty-four (24) hours after treatment**
12. To respond promptly to any requests for information from the insurance carrier or Ireland Grove Center for Surgery
13. To promptly fulfill financial responsibilities and commitments made to Ireland Grove Center for Surgery

I have read and understand my patient rights and agree to fulfill my responsibilities as a patient at Ireland Grove Center for Surgery.

______________________________	______________________________
Patient/Guarantor Signature (if under 18)	Print Patient/Guarantor Name
______________________________	______________________________
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HIPAA PRIVACY PATIENT SIGNATURE FORM

I consent to the use or disclosure of my protected health information by Ireland Grove Center for Surgery for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Ireland Grove Center for Surgery.

I understand that diagnosis and treatment of me by Ireland Grove Center for Surgery may be conditioned upon my consent as evidence by my signature on this document.

I understand I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Ireland Grove Center for Surgery is not required to agree to the restrictions that I may request. However, if Ireland Grove Center for Surgery agrees to the restriction that I request, the restriction is binding on Ireland Grove Center for Surgery.

I have the right to revoke this consent, in writing, at any time, except to the extent Ireland Grove Center for Surgery has taken action on reliance on this consent. My “Protected Health Information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This is protected information related to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I Have the right to review Ireland Grove Center for Surgery’s Notice of Privacy Practices prior to signing this document. Ireland Grove Center for Surgery’s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Ireland Grove Center for Surgery.

The Notice of Privacy Practices is also located at the front office at Ireland Grove Center for Surgery.

The Notice of Privacy Practices also describes my rights and the duties of Ireland Grove Center for Surgery with respect to my protected health information.

Ireland Grove Center for Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling Ireland Grove Center for Surgery and requesting a revised copy be sent in the mail or going to the facility and asking for one at the front desk.

______________________________	______________________________
Patient/Guarantor Signature (if under 18)	Print Patient/Guarantor Name
______________________________	______________________________
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO A DESIGNATED PARTY

I GIVE AUTHORIZATION TO RELEASE MY PRIVATE HEALTH INFORMATION TO THE FOLLOWING:

Designated Party: ____________________________

Relationship to Patient: _______________________

Address: ____________________________________

____

Phone: ____________________________________

Designated Party: ____________________________

Relationship to Patient: _______________________

Address: ____________________________________

____

Phone: ____________________________________

This authorization grants permission to the designated party(ies) named above to:

- ☐ Have access to my entire medical record including any labs, pathology reports, and billing/insurance information

I authorize Ireland Grove Center for Surgery to use and disclose my private health information as described above. The patient or patient's legal representative must read and INITIAL the following statements:

______ I understand the Authorization will expire one (1) year from the date signed unless revoked prior to.

______ I understand that I may revoke this authorization at any time by notifying Ireland Grove Center for Surgery in writing. If I do revoke the authorization, it will not have any effect taken by Ireland Grove Center for Surgery prior to their receipt of the revocation.

____
Patient/Guarantor Signature (if under 18)

____
Print Patient/Guarantor Name

____
Guarantor Relation to Patient

____
Date

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DISCLOSURE OF OWNERSHIP

Ireland Grove Center for Surgery is composed of a Board of Directors with equal ownership. The Board of Directors include: Dr. Edward Kolb, Dr. Dennis Lee, Dr. Ji Li, Dr. Lawrence Li, and Dr. Robert Russell.

The doctor for my procedure today is:

- ☐ Dr. Edward Kolb
- ☐ Dr. Dennis Lee
- ☐ Dr. Ji Li
- ☐ Dr. Lawrence Li
- ☐ Dr. Robert Russell

By signing this form, I acknowledge that I have been informed that my doctor (indicated above) has ownership in Ireland Grove Center for Surgery. I understand that I have a choice in where to receive services for my health care and I agree to continue my care with my doctor.

______________________________________	______________________________
Patient/Guarantor Signature (if under 18)	Print Patient/Guarantor Name
______________________________________	______________________________
Guarantor Relation to Patient	Date