MESQUITE
Gastroenterology and Surgery Center

TERMS AND CONDITIONS OF SERVICE

The patient named on this form is coming to Miguel A. Arenas MD PC for outpatient treatment subject to the following terms and conditions.

1. **Consent for Treatment.** I wish to receive medical care and treatment at the MIGUEL A. ARENAS MD PC. Accordingly, I consent to the treatment, which may be performed during this MIGUEL A. ARENAS MD PC visit, including emergency treatment. I authorize and consent to any of the following: laboratory procedure, other diagnostic procedures, medical treatment, or other clinical and hospital services as directed by my physician(s) or my physician's(s) assistants, which my physician(s) believes are advisable to evaluate or treat me, and to other services rendered under the general and special instructions of my physician(s). I am aware that the practice of medicine is not an exact science. I acknowledge that this MIGUEL A. ARENAS MD PC has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. **Disclosure of Information for Payment Purposes.** I understand my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at MIGUEL A. ARENAS MD PC.

3. **Information to Other Providers.** I understand that in the course of my treatment and/or making arrangements for my care, my information may be shared with other providers. If I prefer that this MIGUEL A. ARENAS MD PC not use or share my information, I may submit a written request for consideration per MIGUEL A. ARENAS MD PC's Notice of Privacy Practices. I authorize reports of my evaluation, treatments, and any follow up evaluations be sent or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician, as well as any other healthcare providers, hospitals, or outpatient facilities and that I have or will identify to you. I permit a copy/fax of this form to serve as an original signature of authorization.

4. **Non-Discrimination Policy.** MIGUEL A. ARENAS MD PC will admit and treat patients within its capabilities regardless of race, color, national origin, religious beliefs, sex, sexual orientation, marital status, veteran's status, age, political beliefs, or disability.

5. **Financial Agreement.** I understand that I will receive a bill from MIGUEL A. ARENAS MD PC. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of MIGUEL A. ARENAS MD PC. I understand that I may also receive a separate bill from the lab for services rendered. MIGUEL A. ARENAS MD PC reserves the right to charge a Late Payment Fee and/or a Returned Check Fee. If I choose to pay all charges myself, I will notify MIGUEL A. ARENAS MD PC prior to receiving service. Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency. **PLEASE NOTE: You will be charged a $50 fee for any appointment that is not cancelled within 24 hours unless there are unforeseen circumstances. You will be charged $150 for any procedure that is not cancelled within 48 hours unless there are unforeseen circumstances.**

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6. **Medicare Coverage** (if applicable). I certify that the information I have been given in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to MIGUEL A. ARENAS MD PC. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to MIGUEL A. ARENAS MD PC for any services provided to me by MIGUEL A. ARENAS MD PC.

7. **Assignment of Benefits.** I hereby authorize assignment of my medical insurance benefits I am due to MIGUEL A. ARENAS MD PC for application to the bill for medical services and supplies I received. I further authorized MIGUEL A. ARENAS MD PC to receive direct payment from my insurance company or third party payer. I agree to remain responsible and liable for payments of all amounts due MIGUEL A. ARENAS MD PC and not received from my insurance carrier(s). I understand MIGUEL A. ARENAS MD PC is submitting claims on my behalf as a courtesy. I SHALL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

9. **Patient's Rights and Responsibilities**. My signature below confirms that I have received the information on MIGUEL A. ARENAS MD PC's Patient Bill of Rights and Responsibilities as a patient.

10. Ownership Disclosure. Miguel A. Arenas, MD is one of the owners of Mesquite Surgery Center, LLC. My signature below confirms that I am aware of his financial interest in Mesquite Surgery Center, LLC. I have a right to choose where to receive services, including a facility where my physician does nor does not have an ownership interest. I have chosen to be treated at this facility.

11. **Medication History**. My signature below authorizes Miguel A. Arenas, MD and the office staff to access my prescription history through SureScripts to maintain an accurate record of my electronic prescriptions.

ACKNOWLEDGEMENT OF RECEIPT OF THIS MEDICAL FACILITY'S NOTICE OF PRIVACY PRACTICES
I have received a copy of this facility's **NOTICE OF PRIVACY PRACTICES.**

12. ADVANCE DIRECTIVES. I acknowledged that I have been provided an opportunity to disclose and discuss any Advanced Directives I have established. I also understand that during my outpatient stay at Mesquite Surgery Center every attempt to comply with these directives will be made by my health care team. My care and interventions will be based on my individual needs and plan. If, during my stay, my condition deteriorates or I experience a life threatening emergency my health care team would always attempt to resuscitate me and transfer me to a local hospital. If I have provided a copy of my Advanced Directives it will be transported with me.

I have read this consent and I am the patient, or the patient's duly authorized representative. On my own behalf (or on the behalf of the patient), I accept and agree to be bound by all of these TERMS AND CONDITIONS OF SERVICE.

Name of Patient or Other Legally Responsible Person, If Applicable: _____
Relationship of Person Authorized to Consent for Patient:_____

_____

Patient Signature Date