RIDGEDALE SURGERY CENTER

14 Ridgedale Avenue * Cedar Knolls, New Jersey 07927 * Tel (973) 605-5151 * Fax (973) 605-1208

PATIENT REGISTRATION

I hereby certify that any information provided to Ridgedale Surgery Center is correct.

I understand that I am responsible for full payment of all charges incurred in connection with this procedure and I agree to make full payment for such charges by cash and/or by assigned insurance benefits. I understand that a deposit will be requested if I have not assigned insurance benefits.

CHECK AGREEMENT: I hereby agree to pay a minimum service charge of $30.00 for each check or other instrument tendered by me but returned to the Surgery Center. I further agree to pay all costs and expenses, including attorney's fees, that are incurred in collecting on such a returned check, draft, or money order. I understand that in addition to its rights to enforce this agreement, the Center may have the rights under state laws relative to collection of returned checks, drafts, or money orders.

Ridgedale Surgery Center does not extend credit and considers all charges due and payable upon receipt of a final bill. If the entire facility account is not paid within sixty (60) days from the date of final bill, or, in the case of a governmental agency (such as Medicare or Medicaid) as primary payer, within sixty (60) days of payment or denial by the agency, there shall be an assessed LATE PAYMENT FEE at the periodic rate of one and one-half percent (1 1/2%) per month on the balance remaining unpaid at the date of billing for the account, which date shall be approximately the same day each month. The minimum monthly late payment fee for balances between $0.00 and $133.00 will be $2.00.

MEDICARE / MEDICAID PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed to process any claim on this or any related procedure. I request that payment of authorized benefits be made in my behalf directly to Ridgedale Surgery Center for its charges and for any charges of physicians for whom the Surgery Center is authorized to bill in connection with its services.

ASSIGNMENT OF BENEFITS: I hereby assign and transfer to Ridgedale Surgery Center all insurance benefits payable to me by my insurance company(s) as specified above for services performed and costs incurred in connection with this procedure. I understand that this assignment of benefits shall be exclusively for the payment of charges for this procedure. I understand and direct that payment of such benefits shall be made by the insurance company(s) directly to the Ridgedale Surgery Center.

I further understand that I am responsible for knowing my healthcare coverage and that I am financially responsible to Ridgedale Surgery Center for all charges incurred in connection with this procedure which are not paid by insurance benefits, including failure to provide Ridgedale Surgery Center with the appropriate referral and/or precertification.

RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW: See Ridgedale Surgery Center Privacy Notice for further explanation.

PERSONAL VALUABLES: It is understood and agreed that Ridgedale Surgery Center shall not be liable for any loss or damage of belongings.

________ **PATIENT RIGHTS**: I have been offered/received a copy of the Ridgedale Surgery Center Patient Rights and verbal explanation of those rights, if necessary.

________ **PRIVACY NOTICE**: I have been offered/received a copy of the Ridgedale Surgery Center Privacy Notice.

________ **ADVANCE DIRECTIVES**: I have been offered information on advance directives.

FINANCIAL AGREEMENT: The undersigned agrees individually and/or agent to the following: in consideration for the services rendered to the patient, he/she obligates himself /herself and the patient to pay the account of the facility in accordance with the regular rates and terms of the facility.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND UNDERSTANDS THE PREVIOUSLY DETAILED STATEMENTS AND ACCEPTS ITS TERMS

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DATE:	SIGNATURE OF PERSON WHO ASSUMES FINANCIAL RESPONSIBILITY
__ __ __ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __ __ __
PATIENT (IF DIFFERENT PERSON THAN RESPONSIBLE PARTY)	WITNESS

ASSIGNMENT OF INSURANCE BENEFITS: I certify that the information provided for health insurance is correct and complete and authorize carriers and/or providers of health care to secure or release information relating to this claim. I understand that I am financially responsible for any amount unpaid by this assignment. I hereby assign any insurance benefits due to me and authorize payment made directly to the **ANESTHESIOLOGIST, PATHOLOGIST OR PHYSICIAN**.

X______________________________	____________
SIGNATURE	DATE