The Surgical Suites
1100 Ward Avenue, Suite 1010
Honolulu, HI 96814

Patient Label

AUTHORIZATION FOR ADMISSION AND TREATMENT

Non-Discrimination Policy
The Surgical Suites ("TSS") admits and treats patients without regard to race, color, national origin, sex, sexual orientation, gender identity, marital status, veteran status, age, disability, or any other characteristic protected by applicable federal or state law. Free language assistance services are available upon request.

Consent to Treatment
I authorize and consent to medical care and treatment at TSS, including diagnostic tests and procedures, as determined necessary by my treating physician(s) and medical providers and performed at their direction.

Patient Rights and Responsibilities
I acknowledge that I have been offered and/or provided access to the document entitled Patient Rights and Responsibilities, available upon request and through the TSS website. I further acknowledge that my physician(s) may have a financial ownership or other financial interest in TSS.

Valuables Policy
TSS is not responsible for loss or damage to personal property kept in my possession. If valuables are stored in a TSS locker, liability is limited to $100 per patient.

Assignment of Insurance Benefits and Payment
I am responsible for payment of my account regardless of insurance coverage. If entitled to insurance benefits, I assign such benefits to TSS and authorize payment directly to TSS.

Medicare / TRICARE Coverage
If applicable, I certify information provided for Medicare or CHAMPUS/TRICARE payment is correct and authorize release of information necessary to determine benefits.

Separate Professional Billing
Physicians and other providers rendering services at TSS may be independent contractors and will bill me separately.

Release of Information / HIPAA Authorization
I acknowledge access to the TSS Notice of Privacy Practices and authorize use and disclosure of my health information as permitted by law for treatment, payment, and healthcare operations.

No Surprises Act Acknowledgment
I acknowledge being informed of my rights under the No Surprises Act, including the availability of a Good Faith Estimate.

Financial Agreement
I am financially responsible for payment of all charges incurred at TSS unless otherwise required by law or arranged in advance. Late payment charges of 1% per month (simple interest) may be assessed on balances not paid within 90 days. Unpaid balances may be referred for collection, and I agree to be responsible for reasonable collection costs as permitted by law.

I certify that I have read and understand this Authorization and agree to be bound by its terms. A copy will be provided upon request.

X _____ Date: _____ Time: _____ a.m./p.m.
Signature of Patient

X _____ Date: _____Time: _____ a.m./p.m.
Signature of Authorized Representative

Relationship: _____

X _____
The Surgical Suites Representative