MONOCACY
SURGERY CENTER LLC

Date: _____

To: Out of Network Members

Re: Non-Participating Provider Agreement

Patient: _____

Account: _____

It is the intention of Monocacy Surgery Center to extend "**in-network benefits"** to all of our patients. Your insurance company will pay the surgery center as a non-participating provider and it is our intention to honor their payment without additional cost to you than if we were a participating or "in-network" provider. It is possible that your insurance payment for your visit to Monocacy Surgery Center, LLC will be sent directly to you. **In the event payment is sent directly to you, please endorse the check over to the center, and mail the check along with the Explanation of Benefits you will receive from your insurance provider.** By sending such payment you receive directly to the center you avoid the possibility of additional costs for using our facility. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and to make any necessary adjustments without the need to bill you for services due to non-payment.

_____ _____

Patient/Responsible Party Date

_____ _____

Witness Date

MONOCACY
SURGERY CENTER LLC

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS, & DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, under any policy of insurance or other health care coverage in which the patient is a covered beneficiary, otherwise payable to me for services, treatments, therapies, including major medical, rendered or provided by the above-named health care provider, including their professional corporations or business entities, including without limitation, if applicable, pathology provider, anesthesia provider, and radiology provider by reason of this admission, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, including major medical, provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chosen action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Medicare: The undersigned parties do hereby assign, transfer and set over any and all Medicare benefits payable for health services relating to this admission to the above-named health care provider, including their professional corporations or business entities, including but not limited to, if applicable, pathology provider, anesthesia provider, and radiology provider, and hereby authorize said healthcare providers or their corporations to submit claims directly to Medicare for payment on behalf of the undersigned patient. Items not covered by Medicare will be the responsibility of the undersigned financially responsible party.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. **THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.**

_____ _____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY DATE

_____ _____

WITNESS DATE

PATIENT LABEL HERE

Patient Name: _____ Date: _____

AUTHORIZATION, ACKNOWLEDGEMENT, ASSIGNMENT AND GUARANTEE

First Colonies Anesthesia Associates, LLC

References to "I", "me" or "my" in this form meant the patient, patient's parent, guardian or representative or any other person signing this form, excepting the person identified as the witness. All references to "you" and "your" in this form mean the physician rendering the professional medical services and/or first Colonies anesthesia Associates, LLC. With the understanding that you will be rendering professional medical services for my treatment, and I have voluntarily given consent for such treatment, I agree to the following:

Authorization and Acknowledgement

For the purpose of reimbursement of fees for services rendered by you during my treatment, I authorize you to release any necessary information to third party payers, insurance companies, attorneys or other relevant parties to secure payment for such services. I also acknowledge and affirmatively represent that the information provided by me regarding my health care coverage is true, accurate and complete to the best of my knowledge.

Assignment of Benefits

I acknowledge and agree that payment(s) I owe for services rendered by you will be assigned and directed to First Colonies Anesthesia Associates LLC. In the event that third party payers, insurance companies, or other entities forward such payment(s) to me, I agree to assign and direct the payment(s) to you immediately upon receipt. Such payment(s) should be delivered to:

First Colonies Anesthesia Associates, LLC, P.O. Box 791344, Baltimore, MD 21279-1344

Guarantee of Payment

I understand that services rendered by you for my treatment at this surgery center will require payment, and I acknowledge and accept complete responsibility for such payment. I further acknowledge, accept responsibility for, and guarantee payment of deductibles, co-pays, or any fees not covered by my insurance company, or any third party payer that were incurred by me as a result of your treatment. If it is determined that no insurance company or third party payer is obligated to pay for such services, or that proceeds from a liability claim will not yield payment for the professional services rendered to you by me, I guarantee such payment. I will make such payment in full no later than three months from the date on which services were rendered to me by you. Should this account be forwarded to a collection agency and/or attorney for collection of any amounts owed by me, I also acknowledge and accept responsibility for payment of all reasonable collection and/or attorney's fees.

_____ _____

Printed Name of Person Signing this Form Signature of patient/Responsible Party

Date: _____ Time: _____AM/PM

Witness: _____ Date: _____ Time: _____AM/PM

MONOCACY
SURGERY CENTER LLC

NOTICE OF PRIVACY PRACTICE as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Monocacy Surgery Center, LLC (MSC) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about the privacy practices at MSC, please see the contact information at the end of this document.

I. HOW MSC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

MSC collects and protects the privacy of your health information. The law permits MSC to use of disclose your health information for the following purposes:

1. TREATMENT: MSC may use your health information to provide you with medical treatment or services. For example, information obtained from you by a front office personnel or nurse is necessary to determine what treatment you should receive.
2. PAYMENT: MSC may use and disclose health information about you for payment for treatment and services you receive. For example, your health information may be sent to a third party payer such as an insurance company or health plan in order for MSC to receive payment for services rendered.
3. HEALTHCARE OPERATIONS: MSC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and other to evaluate the performance of our staff, assess the quality of care and outcomes in your case and similar cases, and to determine how to continually improve the quality and effectiveness of the health care we provide.
4. INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION: You may give MSC written authorization to use or disclose your health information.
5. NOTIFICATION AND COMMUNICATION WITH FAMILY: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. REQUIRED BY LAW: As required by law, MSC may use and disclose your health information. For example, MSC may disclose health information for the following reasons; judicial and administrative proceedings, to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the public or safety of a particular person or the general public.
7. PUBLIC HEALTH: As required by law, MSC may use and disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief, and reporting disease or infection exposure.
8. HEALTH OVERSIGHT ACTIVITIES: MSC may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.

9. DECEASED PERSON INFORMATION AND ORGAN DONATIONS: MSC may disclose your health information to coroners, medical examiners, funeral directors, or to organizations involved in procuring, banking or transplanting organs and tissues.
10. RESEARCH: MSC may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
11. WORKER'S COMPENSATION: MSC may disclose your health information as necessary to comply with worker's compensation laws.
12. MARKETING: MSC may contact you to give you information about treatments or health –related benefits and services that may be of interest to you.
13. GOVERNMENT FUNCTIONS: Specialized government functions such as protection of public officials or reporting to various branches of the armed services may require use or disclosure of your health information.
14. APPOINTMENTS: MSC may use you information to provide appointment reminders by telephone, email or postal service.
15. BUSINESS ASSOCIATES: We work with other businesses to help MSC operate successfully. We may disclose your health information to these business associates so that they can perform the tasks we hired them to do. Our business associates must guarantee us that they will respect the confidentially of your personal health information.

II. WHEN MSC MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in the Notice of Privacy Practices, MSC will not use or disclose your health information without your written authorization.

III. YOUR HEALTH INFORMATION

1. You have the right to request restrictions on certain uses and disclosures of your health information. MSC is not required to agree to the restrictions that you request.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Request must be made in writing detailing the alternative methods chosen and could be applicable to fees.
3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.
4. You have the right to request that MSC amend your health information that is incorrect or incomplete. MSC is not required to change your health information and will provide you information about the denial process.
5. You have the right to receive and accounting or disclosure of your health information made by MSC except that MSC does not have to account for the disclosure described in treatment, payment, healthcare operation, and government functions of section I of this notice. The first accounting of disclosers within a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.
6. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
7. You have the right to obtain a paper copy of this Notice upon request.
8. You have the right to be notified in the event of a breach in MSC's patient information.
9. You have the right to request that your health plan not be informed of your treatment at MSC if you pay in full and your insurance company is not billed.

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

MSC reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, MSC is required by law to comply with this notice. A paper copy of this notice is available if you request a copy.

V. COMPLAINTS

If you believe that your privacy rights have been violated or if you have complaints about this Notice of Privacy Practices, or overall patient safety and care contact the MSC Administrator and/or The Joint Commission at:

Monocacy Surgery Center
4991 New Design Rd. Ste 103
Frederick, MD 21703
Phone: 301-363-5858 Fax: 301-363-5871

The Joint Commission
www.jointcommission.org
In the Search bar type
"Report a Patient Safety Event"

If you are not satisfied with the manner in which MSC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.

_____ _____

Patient/Representative Signature Date

MONOCACY
SURGERY CENTER LLC

AUTHORIZATIONS & DISCLOSURES

These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

AUTHORIZATION FOR MEDICAL TREATMENT: The undersigned hereby authorizes any anesthesia, medical or surgical treatment, including services rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated, as may, in their professional judgment be deemed necessary or beneficial for the purposes of diagnosis, treatment and medical care at Monocacy Surgery Center, LLC. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: For purpose of reimbursement, Monocacy Surgery Center, LLC and each attending or treating practitioner, including, but not limited to, pathology, anesthesia, radiology and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other organizations, third party payers, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third party reimbursement or which could otherwise be harmful or prejudicial to my interests. Unless specifically instructed otherwise, Monocacy Surgery Center, LLC and each attending or treating practitioner are hereby authorized and directed, during the period of this admission, to disclose information to the patient's spouse, children, parents, and any other person authorized to consent to treatment pursuant to 431.061-.065, RSMO (1979) as amended, concerning the patient's health status, diagnosis, prognosis, and progress. Each of the undersigned do hereby release and hold Monocacy Surgery Center, LLC, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss damage, or liability resulting from or arising out of such disclosures.

RELEASE OF RESPONSIBILITY FOR VALUABLES: Monocacy Surgery Center, LLC is hereby fully released of and from any and all responsibility for loss or damage to the personal property, money, or valuables of the undersigned patient.

NOTICE OF PRIVACY PRACTICES: I am aware of my rights to privacy of personal health information, under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and am aware that a copy of these rights are available to me upon request.

RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received, prior to my procedure, a copy of the Patient Rights and Responsibilities, which includes information regarding where and how I can file a grievance or complaint.

PHYSICIAN OWNERSHIP DISCLOSURE: Monocacy Surgery Center, LLC provides services only to patients admitted by private practitioners who are members of the Medical Staff, some of whom retain joint ownership of the surgery center. I understand I may choose another facility for the services I require, and have elected to receive care at Monocacy Surgery Center, LLC.

TRANSPORTATION RELEASE: I understand that the anesthetic to be administered to me may have effects that make it hazardous for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. **I understand that Monocacy Surgery Center, LLC will not perform my schedule procedure unless these arrangements are met, and have provided Monocacy Surgery Center, LLC with my designated responsible party's name and phone number.** The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.

_____ _____ _____

Responsible Party Name Signature Phone Number

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at Monocacy Surgery Center, LLC and I understand that the center policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact) is to initiate resuscitative measures, should an adverse event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney. Please check one of the following:

- O YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record
- O YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me
- O NO, I do not have an Advanced Directive/Living Will/Health Care Proxy
- O I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to Monocacy Surgery Center, LLC for any and all charges associated with the services rendered by Monocacy Surgery Center, LLC, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Monocacy Surgery Center, LLC verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insurance carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all of the charges, Monocacy Surgery Center, LLC will pursue the internal appeals provided by the health plan, and will bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Monocacy Surgery Center, LLC may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.
2. Monocacy Surgery Center, LLC bills both patients and health plans using the same fee schedule, and my financial obligation is based on my applicable benefit levels associated with services for which Monocacy Surgery Center, LLC will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, patients and health plans are offered discounts, in accordance with the Monocacy Surgery Center's Financial Policies, a copy of which is available to me upon request, and has also been made available to my health plan.
4. I am aware of my right to request a complete written estimate of the anticipated charges, and my associated financial responsibility. I understand that the fee quoted to me for the surgery facility is an ESTIMATE only, and it is possible that I will receive a bill for any balance which I remain financially obligated to pay.
5. Fees for anesthesia services, physician fees, pathology services, laboratory fees, durable medical equipment and surgical assistants, or other services rendered which are not included in the facility global rate will be billed separately where applicable.
6. When a payment is received by the patient, directly from the health plan they have assigned to Monocacy Surgery Center, LLC, patient must endorse and forward the payment and Explanation of Benefits to Monocacy Surgery Center, LLC as soon as the payment is received to avoid additional financial liability.

MEDICARE CERTIFICATION AND AUTHORIZATION: Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized by the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.

_____	_____
NAME OF PATIENT	DATE
_____	_____
NAME OF AUTHORIZED REPRESENTATIVE TO DISCUSS ABOUVE NAMED PATIENTS MEDICAL AND/OR FINANCIAL ISSUES IN THEIR ABSENCE	DATE
_____	_____
SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY RELATIONSHIP	DATE
_____	_____
WITNESS	DATE