# POLARIS SPINE AND NEUROSURGERY CENTER, LLC

## OWNERSHIP

I understand physicians Max Steuer, MD, Chris Tomaras, MD, Tom Morrison and Ray Walkup, MD at Polaris Spine and Neurosurgery Center, LLC have equal ownership of the facility. I understand that I may choose to have my surgery in a facility that is not owned by physicians. I have been given this option and choose to have my surgery at Polaris Spine and Neurosurgery Center, LLC.

## RELEASE OF INFORMATION

Polaris Spine and Neurosurgery Center, LLC is hereby authorized to request and/or release any medical records, radiographic or diagnostic imaging results, pertinent to the healthcare of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider. I understand that the information released to these facilities will be used in furthering or processing my claim with my insurance company. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by the physician of Polaris Spine and Neurosurgery Center, LLC. The information released will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

## ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of Polaris Spine and Neurosurgery Center, LLC to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If your carrier is out of network, you are expected to pay at time of service, unless arrangements have been made with the financial advocate. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Polaris Spine and Neurosurgery Center, LLC all surgical, medical insurance and/or other benefits, if any, otherwise payable to me for the services. I agree to endorse the check(s) over to Polaris Spine and Neurosurgery Center, LLC. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to Polaris Spine and Neurosurgery Center, LLC from the obligor of said benefits. Further, I hereby assign and convey Polaris Spine and Neurosurgery Center, LLC, unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person or insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for Polaris Spine and Neurosurgery Center, LLC any settlement proceeds or other proceeds to be paid directly to me, prior to receiving said proceeds. I understand that payment is due when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to Polaris Spine and Neurosurgery Center, LLC. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with Polaris Spine and Neurosurgery Center, LLC be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

## PRESCRIPTION POLICY

Prescriptions and refills for medications are issued during office hours only. 7:00 AM to 3:00 PM, Monday through Friday. No medications will be refilled over the phone after hours or on the weekends. If you have an emergency situation, you will be directed to the emergency department at the local hospital. During the course of treatment with our office, do not obtain pain medications from any other source.

## PATIENT BILL OF RIGHTS NOTICE

I have received and understand the Patient Bill of Rights.

## GRIEVANCE PROCEDURE

All alleged grievances will be acknowledged by administrator to patient within 7 days of receipt and fully documented, investigated and reported to the Administrator of Polaris Spine and Neurosurgery Center, LLC. Any substantiated allegation will be reported to the State and/or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within twenty (20) days of receipt of the grievance. Contact information for the State of Georgia is included on the Patient Bill of Rights. Patient will be kept up-to-date on the grievance status.

## ADVANCE DIRECTIVES

I consent to all resuscitative measures as deemed necessary by my physician in the event of a life threatening emergency. Polaris Spine and Neurosurgery Center, LLC is not equipped to determine if there is a life threatening event; patient will be treated and stabilized, and transported to the hospital of choice by ambulance. I consent to emergency transfer to the hospital in case of the need for emergency hospital care. A copy of the advance directive may be placed on the chart if the patient desires and forwarded to the hospital in the event of a transfer. Information regarding advance directives is made available upon the patient’s request. The admitting facility is not affiliated or in partnership with Polaris Spine and Neurosurgery Center, LLC.