Western PA Surgery Center – Beaver County Branch

Contained in this packet is information about the Surgery Center that is important for you to review prior to the day of your surgery.

Enclosed are the following:

1. A brochure that gives you an overview of the preparation for surgery, key points for after surgery and directions to the facility.
2. The Patient Bill of Rights and Responsibilities.
3. As the Surgery Center is an outpatient center that performs only elective and no high risk procedures, we do not honor advance directives. If there is an emergency, we wi11 call 911 and perform emergency treatment. If you have an advance directive in place you may bring it with you in case you are transferred to the hospital.
4. The Western PA Surgery Center is a privately owned facility. Your surgeon may or may not be an investor. A list of surgeons who have ownership is enclosed.

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, AND CREDIT AGREEMENT

RELEASE OF INFORMATION: A photocopy of this information is to be considered as valid as an original and revocable by me only in writing. I agree to permit the Western PA Surgery Center to provide me a copy of my medical records or other information to my insurance company or other responsible payers if a request is made.

FINANCIAL RESPONSIBILITY: I ACCEPT ULTIMATE FINANCIAL RESPONSIBILITYFOR ACCOUNTS WITH THE WESTERN PA SURGERY CENTER, WHETHER PAID BY INSURANCE OR NOT. ANESTHESIA SERVICES ARE BILLED SEPARATELY BY THE ANESTHESIA PROVIDER AT OUR FACILITY.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private and group insurance,or other health plan to the Western PA Surgery Center. I understand that I am responsible to pay the bill in full for all services to me and my dependent(s) by the Western PA Surgery Center and itspersonnel. I agree that I will pay any bill furnished by Western PA Surgery Center within 90 days of receipt or 6 months (if making consistent monthly payments). If the bill is not paid within 90 days or if consistent monthly payments within the 6-month period are not made, I understand that my account will be turned over to a collection agency, and I agree to pay any attorney's fee and collection expenses related to that. I agree that I will pay Western PA Surgery Center its usual charge for the Surgery Center services rendered. I also understand that this acknowledgment covers bills issued on behalf of the Western PA Surgery Center. Anesthesia services and the surgeon fees are bil1ed separately.

VALUABLES AND PERSONAL ITEMS: I assume full responsibility for any of my personal effects while receiving services at Western PA Surgery Center, 301 Pleasant Dr., Aliquippa, PA 15001

Please sign, date and bring this letter to the Surgery Center on the day of your procedure.It signifies that you have read and understood the enclosed information. The receptionist will ask you to produce this letter as part of the admission process.
If you have any questions about the information, please feel free to call. We will be happy to assist you. The Surgery Center's number is 724-203-3340

Name_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date _ _ _ _ _ _ Time _ _ _ _

Admitted by: _