CANYONRIDGE
Surgery Center

PATIENT REGISTRATION

Name : _____ Age:_____ Birthday:____/____/____ Sex: M / F

Address:_____ City:_____State:_____ Zip code:_____

HOME NO: (____)_____ CELL NO: (____)_____

WK NO: (____)_____ EMAIL: _____

Financial Responsibility: I understand that it is my responsibility to know and verify if benefits contained in my insurance plan limit, reduce or deny coverage of any services provided by CANYON RIDGE SURGERY CENTER. I agree to reimburse CANYON RIDGE SURGERY CENTER for deductibles, co-payments, coverage penalties, or services that are not a covered benefit of my health care plan. Even though you have assigned your benefits to by CANYON RIDGE SURGERY CENTER, your Insurance Company may send payment for services rendered at CANYON RIDGE SURGERY CENTER directly to you. Please endorse the back of the check, or send a personal check for the amount and a copy of the Explanation of Benefits to the address below upon receipt. After payment is received we will make any adjustments to your account per our conversation. Failure to remit entire amount paid by your insurance company will result in collection action. Payments will not be in lieu of the amount paid by your insurance company.

Authorization: I authorize direct payment to CANYON RIDGE SURGERY CENTER of any of my insurance benefit otherwise payable to me for the care rendered by CANYON RIDGE SURGERY CENTER. I also give power of attorney to endorse/sign my name on any checks for payment of CANYON RIDGE SURGERY CENTER bill. It is understood by me that I am financially responsible for charges not covered by this agreement. All delinquent accounts shall be charged a one and one-half percent interest charge per month.

CANYON RIDGE SURGERY CENTER will release patient medical records and insurance information to any third-party payer if applicable (anesthesia, pathology, radiology, and laboratory). CANYON RIDGE SURGERY CENTER is not responsible for the loss of valuables. It is also understood that CANYON RIDGE SURGERY CENTER (or its billing agent) will bill my insurance carrier as a courtesy to me. Any charges not paid for by the carrier become due by me. To the extent necessary to obtain reimbursement, CANYON RIDGE SURGERY CENTER (or its billing agent) may disclose any portion of my record, including my medical records, to any party the patient has identified as liable for any portion of CANYON RIDGE SURGERY CENTER.

Advance Directive: I understand that I have the right to make choices regarding life-sustaining treatment (resuscitative measures.)

- Y/N Yes, I have provided the facility with a copy of my Advance Directive/Living Will/Health Cary Proxy.
- Y/N The facility has explained to me their policy regarding the honoring of this document and I agree to proceed as scheduled.
- Y/N Yes, I have an Advance Directive/Living Will/Health Care Proxy, but I did not bring it to the Surgery Center.
- Y/N I do not have an Advance Directive/Living Will/Health Care Proxy.

I understand that if I have an Advanced Directive in place for no resuscitation that this will be discussed with the physician at the time of the procedure whether to honor that request at the facility. At that time it will be documented in my chart the final decision.

I hereby authorize and consent to being transferred via ambulance to a hospital if my physician determines that is necessary. I hereby release my medical records.

Ownership Disclosure: I am aware that NSCC, LLC, and Stephen Gephardt, MD, have interest in CANYON RIDGE SURGERY CENTER. I understand that I may choose another outpatient facility for the purpose of having my procedure performed. I have decided to have my procedure at CANYON RIDGE SURGERY CENTER.
Patient concerns and/or grievances. Persons who have a concern or grievance against CANYON RIDGE SURGERY CENTER but not limited to, decisions regarding admission, treatment, discharge, denial of services, quality of services, courtesy of personnel or any other issue are encouraged to contact the administrator or write a statement: **Attn: CANYON RIDGE SURGERY CENTER, at 5852 S. Durango Dr., Unit 100, Las Vegas, NV 89113**
I have received copies of my information on patient rights, patient responsibilities, physician disclosure, advanced directive policy and grievance policy.
I authorize CANYON RIDGE SURGERY CENTERS to contact me to verify appointments, to discuss test results and recommendations, and to get additional information.

Phone Number_____

Patient Signature: _____ Date: _____

Patients Legal Representative: _____ Date: _____

Drivers Name: _____ Drivers Signature: _____

Witness: _____ Date: _____