Please sign and bring the day of Surgery

ROBERT RIEDERMAN, M.D.
IAN M. WEINER, M.D.
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PETER R. JAY, M.D.
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LISA J. GRANT, M.D.
CHAD C. ZOOKER, M.D.
JONAH HELLER, M.D.

PHYSICIAN OWNED FACILITY

I understand that the physicians on staff at Greenspring Surgery Center providing medical services may have an ownership interest in the facility. I understand that I may choose to have my surgery in another facility. I have been given this option and choose to have my surgery at Greenspring Surgery Center.

ADVANCE DIRECTIVES

I consent to all resuscitative measures as deemed necessary by my physicians in the event of a life threatening emergency. Unexpected complications due to anesthesia and/or surgery are not natural causes and therefore will be treated and you will be transferred to a higher level of care facility along with a copy of the advance directive if provided. I consent to emergency transfer to another facility in case of the need for emergency hospital care. The admitting facility is not in partnership with Greenspring Surgery Center LLC.

RELEASE OF INFORMATION

I, hereby authorize Greenspring Surgery Center LLC to release any information acquired in the course of my examination, treatment, procedure to: Any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, or insurance company. I understand that the information released to these facilities will be used in furthering or processing my claim with my insurance. 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.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS

I hereby instruct and direct my insurance carrier and/or third party payer to pay by check made out and mailed to:

Greenspring Surgery Center LLC
2700 Quarry Lake Drive, Suite 100
Baltimore, MD 21209

for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **This is a direct assignment of my rights and benefits under this policy.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize Greenspring Surgery Center LLC to initial a complaint to the Insurance Commissioner for any reason on my behalf.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated and reported to the persons in authority at Greenspring Surgery Center, 2700 Quarry Lake Drive, Suite 100, Baltimore, MD 21209, 410-653-0077. Complaints and concerns may also be reported to the state agency at: Maryland Department of Mental Health and Hygiene, Office of Health Care Quality, 7120 Samuel Morse Drive, 2nd Floor. Columbia, Maryland 21228 1-410-402-8040

I have read and understand the above:

____ ______________________
Signature of Patient or Responsible Party Date Time