G#____________ **Associated Surgeons & Physicians, LLC (ASAP)**

NOTICE OF FINANCIAL INTEREST IN HEALTH CARE ENTITY

The undersigned individual is hereby notified by his/her treating/referring physician (the "Physician"), who is associated with by Associated Surgeons & Physicians (ASAP) that, by virtue of the Physician's association with ASAP, the Physician may have part-ownership or a financial interest in one of the hospitals within the Lutheran Network. The Physician believes the Hospital is an appropriate setting for the medical care and services for which the undersigned is being referred. Nevertheless, the selection of a specific health care entity/facility always rests with the patient, and as such, the undersigned may choose to be referred to an alternate entity/facility of his/her choice. The undersigned hereby acknowledges and certifies that he/she has received a copy of the Notice of Financial Interest in Health Care Entity.

CONSENT FOR TREATMENT OF ADULT

I (the patient) hereby consent to the administration of health care (including care, treatment, services, examinations, tests, consultations or procedures to maintain, diagnose or treat me (the patient) by Associated Surgeons & Physicians (ASAP). This Consent for Treatment shall specifically include tests for the presences/absence of alcohol or controlled substances. By my signature below, I acknowledge that I am giving my consent to the administration of health care by ASAP voluntarily, and that I hereby knowingly and voluntarily enter into this Consent for Treatment. I have been informed and acknowledge that I may withdraw my consent hereunder at any time upon written notice to ASAP.

CONSENT FOR TREATMENT OF MINOR

I am the (circle one) parent/guardian/custodian/legally authorized representative/other _______________ (describe) of __________________, an un-emancipated minor child who is ______ years of age (hereafter the "Patient") and I have authority to execute this Consent for Treatment on behalf of the Patient. I hereby consent to the administration of health care (including care, treatment, services, examinations, test, consultations or procedures to maintain, diagnose or treat the patient's condition) by Associated Surgeons & Physicians (ASAP) for the Patient. The conditions or limitations, if any, on my consent and the authority delegated to ASAP hereunder include: ________________________________ The consent for Treatment shall specifically include tests for the presence/absence of alcohol or controlled substances. By my signature below, I acknowledge that I am giving my consent to the administration of health care by ASAP for the Patient voluntarily, and that I hereby knowingly and voluntarily enter into the Consent for Treatment. Due to the Patient's inability to sign this Consent for Treatment, I hereby agree on behalf of the Patient, to sign for the Patient, and to bind the patient to the terms of this Consent for Treatment. I have been informed and acknowledge that I may withdraw my consent hereunder at any time upon written notice to ASAP.

AGREEMENT TO PAY

I agree that I am responsible for payment for all services provided to me by Associated Surgeons & Physicians (ASAP), subject to limitations set forth in any applicable insurance or other third-party benefits contract. I agree that I will pay all applicable insurance co-payments and deductibles. I further agree that I will pay all other outstanding balances for which I am responsible. Specifically, I will be responsible for any services: which Medicare, Medicaid, Medigap or my insurance or other third-party benefits plan determines are not covered; for which the benefits have been exhausted; for which I fail to obtain any required authorization from my primary care physician; and, for which any spend down amount has not been met. I will also be responsible for any out-of-network fees and for any other amounts which are due and are not required to be written off by the contract ASAP has with my insurance or other third-party benefits carrier. I agree to pay such amounts within 30 days of being notified by ASAP of the balance due. *I understand that if I fail to pay my balance, my account may be turned over to a collection agency or attorney. In such an event, I agree that I will be responsible for all collection fees (including reasonable legal fees, interest, and court costs).*

ASSIGNMENT OF BENEFITS

I hereby assign to ASAP all rights I have to be reimbursed for medical expenses generated by ASAP with respect to Medicare, Medigap, Medicaid and/or any other insurance carrier, including any plan or policy of insurance (group or individual), flexible spending account, health savings account, health reimbursement arrangement or similar plan or reimbursement mechanism. This assignment includes all rights that I may have under ERISA, including but not limited to all rights concerning obtaining copies of plan/policy documents, rights to reasonable and customary fee schedules, and rights to appeal any full or partial claim denial for treatment by ASAP. In addition, I hereby request that payment of any authorized Medicare benefits, Medigap benefits, Medicaid benefits and or/insurance or other third party benefits be made directly to ASAP. If said benefits are not paid directly to ASAP, I agree to forward to ASAP all payments that I receive immediately upon my receipt. To assist in this process, I authorize any holder of medical information about me to release to CMS, my Medigap insurer, Indiana health Coverage Programs/Medicaid and/or any other insurance or third-party payor and their respective agents any information needed to determine the benefits payable for the services rendered to me.

ACKNOWLEDGEMENT AND RELEASE

I hereby authorize Associated Surgeons & Physicians (ASAP) and all physicians and providers involved with my care to release information from my medical records as may be required to any person, corporation, or agency which is legally responsible or which ASAP has good cause to believe is legally responsible, for processing and/or paying all or any part of ASAP charges and/or professional fees; and, to any entity which has contracted with any insurer to conduct utilization or performance review. I hereby authorize ASAP and any affiliated physician or provider involved with my care to release information to any physician or provider to which I may be transferred for further medical care.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been offered the opportunity by Associated Surgeons & Physicians to receive a copy of the Notice of Privacy Practices.

PRINTED NAME OF RESPONSIBLE PARTY_______________________________________ DATE_________________

SIGNATURE OF RESPONSIBLE PARTY____ RELATIONSHIP TO PATIENT_______________