FINANCIAL RESPONSIBILITY, AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND OTHER ACKNOWLEDGEMENTS

In consideration of the services to be rendered to the patient, the undersigned (as the patient, the patient's legal representative, parent, guardian, spouse, guarantor, or agent) individually promises and agrees to pay the patient's account at the rates and terms stated in the Surgery Center's price list (known as the "Charge Master") effective on the date of service, which rates are hereby expressly incorporated by reference as the price terms of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or the charge is listed as zero. In the event that the Surgery Center has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to and services provided herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses, including, without limitation, collection agency expenses, incurred by the Surgery Center.

________ INITIAL

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Surgery Center. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

In consideration of facility, medical and/or anesthesia services rendered to me or my dependents, I hereby assign and transfer any benefits due me under an insurance policy in so far as they are necessary to cover the expenses. If I maintain an insurance policy, then I, as the policy holder, do hereby authorize the payment of any benefits due me or my dependents under such policy in accordance with this assignment.

________ INITIAL

The insurance information that has been supplied to this facility is ____________________ and this center {❑ is ❑ is not} a participating provider of services with your insurance plan. Furthermore, the physician or other healthcare provider(s) who may provide you service today may not be participating providers with your insurance plan.

________ INITIAL

You will receive separate bills from the pathologist, radiologist, anesthesiologist, durable medical equipment provider, treating and consulting physicians who have provided services to you at the Surgery Center. I recognize that any and all physicians, fellows and/or residents who furnish services to me during this admission are independent contractors and ARE NOT AGENTS OR EMPLOYEES OF THE SURGERY CENTER.

1. Are you currently receiving Medicare Benefits? ❑ Yes ❑ No (if "Yes", please answer questions 2 & 3)
2. Are either you or your spouse currently working? ❑ Yes ❑ No
3. Are either you or your spouse currently provided with any group health coverage? ❑ Yes ❑ No

If yes; Insurance Name: ____________________ Policy # ______________ Group # ____________

________ INITIAL

I authorize the release of medical, protected health and insurance information to the admitting physician, emergency physician, anesthesiologist, radiologist, pathologist, consulting physician, and institutions performing special tests or providing special equipment or supplies and the receiving hospital or institution in the case of a medically necessary transfer. I further request payment of Medicare or other insurance benefits be made to these physicians for professional services rendered while I, or one of my dependents was a patient at the Surgery Center. The undersigned agrees that all records concerning this patient's admission shall remain the property of the facility.

The Surgery Center may use or disclose information about you to bill or receive payment for medical treatment or services and/or supplies provided to you to which you consent to by your signature below. These disclosures include, but are not limited to, releasing information:

1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; and
2) to individuals or entities involved in collecting amounts owed to us.

________ *INITIAL*

I have received this Surgery Center's Notice of Privacy Practices. I understand that if I have any questions or complaints I may contact the Surgery Center's Facility Privacy Official.

________ *INITIAL*

I have received verbal and written notice of the Surgery Center's Statement of Patient Rights and Responsibilities, and Advance Directives form, which I have read and understand as stated therein.

________ *INITIAL*

I understand that my surgeon ❑ does ❑ does not have a financial interest or ownership in the Surgery Center.

________ *INITIAL*

The center or representative will contact you and or the guarantor by any and all means that have been provided including cell phones or by automated dialers.

Signature____

Patient/Legal Guardian | Date | Witness | Time

If the patient is a minor or unable to sign, complete the following: ❑ Patient is a minor

❑ Patient is unable to sign because: ____

______________________ ______________________ ______________________

Patient | Parent/Legally Designated Representative | Relationship to Patient

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed:

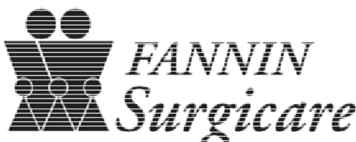
Name ______________________

Name ______________________

Name ______________________

______________________ Signature of Patient

PATIENT IDENTIFICATION:



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