FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

You will be given a copy of the following information to sign on the day of your procedure. Please read and indicate your understanding by signing and dating.

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. 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.

- An estimate of your out of pocket amount will be provided to you. 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. Post-surgery, you may request a copy of your charges from the Surgery Center.
- In consideration of facility, medical and /or anesthesia services rendered to you or your dependents, you hereby assign and transfer any benefits due to you under an insurance policy in so far as they are necessary to cover your expenses. If you maintain an insurance policy, then you, as the policy holder, do hereby authorize the payment of any benefits due you or your dependents under such policy in accordance with this assignment.
- Insurance information will be provided to the Center. You will be notified if your insurance carrier does not participate with Capital City Surgery Center. Furthermore, the physician or other healthcare provider(s) who may provide you service today may not be participating providers with your insurance plan.
- You will receive separate bills from the pathologist, radiologist, anesthesiologists, durable medical equipment, treating and/or consulting physicians who have provided services to you at the Surgery Center.
- You 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. You further request payment of Medicare or other insurance benefits be made to these physicians for professional services rendered while you, or one of your dependents was a patient at the Surgery Center. The undersigned agrees that all records concerning the 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.

- You have received this Surgery Center's Notice of Privacy Practices. You understand that if you have any questions or complaints you may contact the Surgery Center's Facility Privacy Official.
- You have been provided verbal and written notice of the Patient Rights and Responsibilities in advance of the date of your procedure in a language and manner you understand.
- You have been made aware that your physician may have a minority financial interest in Capital City Surgery Center.

Signature:_____ Date:_____

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

- ☐ The patient is a minor.
- ☐ The patient is unable to sign because_____

Patient's name:_____

Parent's name:_____

Legally Designated Representative:_____

Relationship if Patient Does Not Sign_____

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 below.

Name:_____

Signature of Patient:_____

Updated: October 2016