Capital City Surgery Center
23 Sunnybrook Road, Ste 100,
Raleigh, NC 27610

FINANCIAL AGREEMENT

Capital City Surgery Center ("CCSC") and _____ ("Patient") agree to the following terms:

Patient's Initials

1. On or about _____, 202___, Patient will be receiving the following outpatient surgery at CCSC: _____
_____

Patient's Initials

2. A list of the estimated charges as determined by the scheduled services to be performed is available at the patient's request. The total estimated out of pocket due for the services provided by CCSC will be: $_____. Exhibit A provides the patient the payment agreement made between the patient and the center.

Patient's Initials

3. Patient understands that the amount of CCSC charges set forth above does NOT INCLUDE services delivered by physicians or other providers other than CCSC including the surgeon(s), anesthesiologist(s), pathologist(s) and durable medical equipment suppliers that will work on this case at CCSC, and Patient will receive additional bills for these services from their other providers/suppliers.

Patient's Initials

4. CCSC has made reasonable inquiry with the Patient's health plan or other third party payor to determine how much of CCSC's fee will be paid by Patient's health plan or other third party payor, however, CCSC has no reasonable way to identify this amount with precision in advance, and is dependent upon non-binding information received from Patient's health plan or other third party payor. Patient understands that Patient is responsible for all charges of CCSC for services delivered by CCSC to Patient as set forth in Paragraph 2 above to the extent that CCSC is not paid for such services by Patient's health plan or other third party payor within a reasonable amount of time following the delivery of services hereunder. Patient's responsibility includes CCSC charges for benefits that are not covered or denied under Patient's health plan/health coverage, as well as patient co-payments and deductibles.

Patient's Initials

5. The insurance information that has been supplied to this facility is _____
_____ and CCSC ____ is/ ____ is not a participating provider of services with Patient's insurance plan. Note that the physician or other physicians and/or durable medical equipment suppliers who provide Patient with services at CCSC may or may not be preferred providers in Patient's health plan or other third party Payor, which would impact the amount of fees that Patient is responsible for, for receipt of the services delivered to Patient by CCSC, and the physicians providing care to Patient at CCSC.

Patient's Initials

6. Patient agrees to pay CCSC's fees within 30 days following issuance of a CCSC invoice for the services provided herein unless Patient has arranged to enter into a payment plan with CCSC for a more extended payment plan. CCSC will only agree to an extended payment plan in writing.

Patient's Initials

7. Patient agrees to pay CCSC reasonable collection costs (including the cost of a CCSC collection agency and attorney's fees) to the extent CCSC must incur these costs to collect payment as set forth in this Financial Agreement.

Patient's Initials

8. In consideration of the services rendered to Patient, Patient hereby assigns and transfers any benefits due Patient under any health plan or insurance policy in so far as they are necessary to cover the expenses incurred pursuant to this Financial Agreement. If Patient maintains an insurance policy, then Patient, as the policy holder, does hereby authorize the payment of any benefits due Patient or the dependants under such policy in accordance of this assignment.

Patient's Initials

9. Patient has received CCSC's Notice of Privacy Practices. Patient understands that if Patient has any questions or complaints about its content Patient may contact the CCSC Privacy Official at **919-322-4816**.

Patient's Initials

10. Patient is aware that one or more of the physicians that perform services for Patient at CCSC may have a financial interest in CCSC and that Patient is free to obtain services elsewhere.

Patient's Initials

11. If Patient is a minor or is unable to sign, complete the following:

☐Patient is a minor

☐Patient is unable to sign because

Relationship to Patient if Patient does not sign _____

Patient's Initials

12. Patient authorizes CCSC to disclose financial information about their care to the following individual: _____

PRINT NAME

AGREED TO AND ACCEPTED:

CAPTIAL CITY SURGERY CENTER

_____

Authorized CCSC Representative

_____

Patient

_____

Patient Representative

Date:_____

Patient Label

MPG_CCS009