BELTLINE SURGERY CENTER

FINANCIAL RESPONSIBILITY
AND
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

In consideration of the services to be rendered to the patient, the undersigned individually promises and agrees to pay the patient's account at the rates and terms stated in the Surgery Center's price list 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. 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 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.

In consideration of facility medical and/or anesthesia services rendered to me, 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, I as the policy holder, do hereby authorize payment of any benefits due me under such policy in accordance with this Agreement.

You will receive separate bills from the pathologist, radiologist, anesthesiologist, treating, and consulting physicians who have provided services to you at the Surgery Center. 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 authorization or to determine whether your plan will cover the treatment or services; and
2. to individuals or entities involved in collecting amounts owed.

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. I further request payment of Medicare or other insurance benefits be made to these physicians for professional services rendered while I was a patient at the Surgery Center.

Initial:_______ I acknowledge that a copy of the Privacy Notice is available to me upon request and is posted in the waiting area. I understand that if I have any questions or complaints, I may contact the Surgery Center's HIPAA Compliance Officer.

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

Name:___________________________________ Name:___________________________________

Name:___________________________________ Name:___________________________________

Signature:___________________________________ **Date:________________________**

If not patient, relationship to patient:____