DURANGO
Outpatient Surgery Center
Affiliate of St. Rose Dominican Hospitals

FINANCIAL POLICY

1. The patient is responsible for all charges incurred at Durango Outpatient Surgery Center (DOSC). A bill from DOSC for the use of the facility will be sent to the patient and /or the patient's responsible party. The charges on the bill cover the use of pre-op, operating and recovery rooms, medications, supplies, instruments, equipment and the facility staff. These charges do not include any professional physician fees for anesthesia, surgery, pathology, radiology, etc. and any pre-operative testing fees.

2. If you have insurance, DOSC will file a claim for you as a courtesy. If you have not been notified of payment from them my the sixth week following surgery, you should contact your carrier. If you have a deductible, co-pay, or co-insurance due, payment arrangements must be made prior to surgery. Any non-covered amounts, amounts over the usual and customary and compliance penalties will be billed to the patient.

3. DOSC has contracts with many managed care organizations. You are expected to follow the rules of your carrier in obtaining pre-authorizations, referrals, etc. DOSC will assist you with this process if needed and abide by all the rules of these contracts. If DOSC does not have a contract with your carrier, they will attempt to negotiate rates for your procedure with your insurance company/managed care organization but cannot guarantee the result.

4. If you do not have insurance, payment arrangements must be made prior to surgery. If requested, a price quote of charges for your procedure will be given. These quotes are based on averages and may vary significantly from actual charges because every patient's surgery is different. These quotations will not include any physician fees or services.

RELEASE OF INFORMATION

5. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, DOSC may disclose portions of the patient's record, including his/her medical records to any person or corporation which is or may be liable for all or any portion of DOSC charges, including but not limited to insurance companies, health care service plans, workers' compensation carriers, the patient's employer, and utilization review monitoring organizations.

ASSIGNMENT OF BENEFITS

6. I authorize direct payment to DOSC and to the full extent of my authority, I hereby assign to DOSC any insurance benefits otherwise payable to the patient or on the patient or on the patient's behalf for the patient's surgery, treatment or diagnostic procedure(s). It is agreed that payment to DOSC pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that the patient is financially responsible for charges not covered by this assignment.

FINANCIAL AGREEMENT

7. I agree that payment for all charges incurred are the primary responsibility of the patient or the patient's responsible party. I authorize DOSC or its agent to check with any credit bureau, and to verify the patient's employment or insurance coverage. If the account is sent to any attorney for collection, the patient shall pay, in addition to all sums due, DOSC reasonable attorney's fee and collection expense. If any of my checks are returned by my bank, I understand that I will be charged an additional fee at the prevailing rate at that time.

8. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. I also understand that a photocopy of this release is as valid as the original.

Patient/Parent/Agent (Electronic Signature): _____ Date _____ Time_____

Relationship to Patient_____ Witness_____