St Joseph's Outpatient Surgery Center – 240 West Thomas – Phoenix, AZ 85013 – 602-406-3552

FINANCIAL POLICY

The patient is responsible for all charges incurred at St Joseph's Outpatient Surgery Center (SJOSC). A bill from SJOS 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. <u>These charges do not include a professional physician fee for anesthesia, surgeon, pathology, etc. and any pre-operative testing fees.</u>

If you have insurance SJOSC will file a claim for you as a courtesy. A copy of your insurance card and photo identification is needed prior to or on the day of surgery. If you have a deductible, co-pay or co-insurance due, payment arrangements must be made prior to surgery. I understand that if I have been quoted a facility fee, that it is subject to change if more procedures are performed than originally scheduled a different procedure is performed. Any non-covered amounts, amounts over the usual and customary and compliance penalties will be billed to the patient. Cosmetic procedures must be paid in full prior to surgery.

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

If you do not have insurance, payment arrangements must be made prior to surgery. If requested, a price quote or charges for our 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 fee or services.

RELEASE OF INFORMATION

I acknowledge that one of more of the physicians providing treatment to St Joseph's Outpatient Surgery Center/Recovery Care Center may have an ownership interest in this facility. I also acknowledge that I have the right to choose the provider of my healthcare services and have chosen St Joseph's Outpatient Surgery Center.

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

ASSIGNMENT OF BENEFITS

I authorize direct payment to SJOSC and to the full extent of my authority, I hereby assign to SJOSC and insurance benefits otherwise payable to the patient or on the patient's behalf for the patient's surgery. It is agreed that payment to SJOSC, 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

I agree that payment for all charges incurred is the primary responsibility of the patient or the patient's responsible party. I authorize SJOSC or its agent to verify the patient's employment or insurance coverage. If the account is sent to a collection agency, the patient shall pay, in addition to all sums due to SJOSC, reasonable collection fees. 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.

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 dully 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 valid as the original.

Patient/Parent/Agent:____ Date:____________________

Relationship to Patient:____