

DAY SURGERY CENTER
2400 Dundee Road
Winter Haven, Florida 33884

Financial Policy

Patient name: _____

Patient Social Security No.: _____

Patient address: _____

Patient telephone number: _____

Thank you for choosing Physicians of Winter Haven, L.L.C. d/b/a Day Surgery Center as part of your health care provider. The following is a statement of our Financial Policy, which we ask you to read and sign.

The undersigned patient and/or guaranteeing party agrees to the following:

1. INSURANCE COVERAGE. Due to frequent changes in health insurance coverage, DSC requires that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of coverage, or are on a plan in which DSC does not participate, full payment is required at the time of your visit. It is very important that you take an active role in understanding your insurance benefits. It is impossible for us to keep track of all the individual requirements of each plan and each company. Please make sure that you understand the benefits and requirements of your plan and be aware of any changes that may occur over time.

2. PAYMENT METHODS. All co-payments and deductibles are due at time of service. **These fees by law cannot be waived.** For your convenience, we accept cash, check, check cards, VISA/MASTERCARD.

3. CONTRACTUAL INSURANCE. If we are a participating provider, all co-pays and co-insurance amounts are due at time of service. We will routinely file your insurance claim for each visit. Should there be a dispute with your insurance company, we will attempt to resolve it for you. A statement will be mailed to you only if you are responsible for payment. For all insurances other than HMOs, if your insurance has not paid DSC within 60 days, you will receive a bill from DSC for the balance which is payable in full upon receipt. **Your insurance is a contract between you and your insurance company; therefore, your balance is your responsibility.** Some of the services provided may be non-covered services and not paid by your insurance coverage. You are personally responsible for those services. **If payment is made directly to you or your spouse by your insurance company, you agree that within 5 days of receiving the check you will endorse the check or cause the check to be endorsed and deliver the endorsed check to DSC or write and deliver a check for the same amount to DSC. Otherwise, you will be responsible for the FULL REMAINING BALANCE. NO DISCOUNTS WILL BE GIVEN if you do not pay with-in five days of receiving the payment from your insurance company.**

4. NON-CONTRACTUAL INSURANCE. For those plans with which DSC does not have a relationship, DSC will send a copy of your bill to your insurance company as a courtesy. **If payment is made directly to you or your spouse by your insurance company, you agree that within 5 days of receiving the check you will endorse the check or cause the check to be endorsed and deliver the endorsed check to DSC or write and deliver a check for the same amount to DSC. Otherwise, you will be responsible for the FULL REMAINING BALANCE. NO DISCOUNTS WILL BE GIVEN if you do not pay with-in five days of receiving the payment from your insurance company.**

5. AUTHORIZATION TO DISCLOSURE AND RECEIVE INFORMATION. The undersigned hereby authorizes DSC to release and obtain information from insurance carriers listed on this record or any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, such diagnostic and therapeutic information and records **(including any treatment or testing for mental illness, alcohol abuse, drug abuse, or HIV/AIDS)** as may be necessary to determine benefits entitlement and to process payment claims for health care provided to the above named patient. This authorization shall be valid only for the period of time necessary to actually process payment claims pertaining to the patient, but in any case shall cease to be valid 18 months from this date. I also authorize release of medical and financial information to my personal physician or any physician who attended me during my care or any physician who cares for me post discharge for ongoing care, and to agencies and professionals cooperating with DSC in the discharge planning process. **I understand that the above authorizations are subject to revocation except to the extent that action has been taken in reliance thereon.**

6. IRREVOCABLE ASSIGNMENT FOR INSURANCE BENEFITS AND APPOINTMENT OF AUTHORIZED REPRESENTATIVE. I hereby assign to DSC any and all rights and causes of action I may have to or for insurance benefits, of any nature, whether third party or otherwise, and I appoint DSC as an authorized representative for my Employee Benefits or ERISA qualified plan. This assignment includes any and all Personal Injury Protection coverage (PIP), health, disability, liability coverage, self-insurance, employment based benefits, third party insurance coverage or any other insurance coverage. I authorize and direct any insurance carrier, including third-party carriers, or benefits administrator, responsible for payment in whole or in part of the patient's (my) health care bill, to accept claims from, and to pay directly to DSC all the insurance or benefits or coverage otherwise payable to, or for, (me) the patient, but not to exceed DSC's regular charges for the services for which payment is due to DSC. This assignment and appointment includes authorization for any and all legal remedies, to include applications, determination of eligibility, claims and appeals for benefits to enforce payment of the insurance or benefits proceeds. DSC is under no obligation to bring any action against any party. DSC may transfer this assignment at its

discretion or apply it to any physician services provided by DSC. Any waiver of this assignment, or appointment, must be in writing from an authorized DSC representative.

7. RELEASE OF RESPONSIBILITY FOR PERSONAL ARTICLES. It is understood and agreed that DSC shall not be liable for the loss of or damage to any money, jewelry, contact lenses, general prosthesis, eyeglasses, dentures, documents, wearing apparel, radios, purse, wallet, or other articles of value that I bring to DSC. If I bring such items with me, I understand that I will assume all responsibility for their loss or damage regardless of the cause of the loss or damage.

8. AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT. I hereby authorize DSC and the physician or physicians in charge of the care of the above named patient to administer any treatment, to administer such anesthetics and medications, to perform such operations (including blood transfusions), to perform such laboratory procedures and tests (including but not limited to blood tests for HIV/AIDS), and to dispose of any tissues, body parts, or organs removed as he, she, or they deem necessary or advisable in the diagnosis and treatment of this patient. I further direct DSC, its agents, and employees to follow the instructions and directions of the physician or physicians in charge of the care of the above named patient. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in DSC.

9. STATEMENT OF FINANCIAL RESPONSIBILITY. In consideration of medical treatment and services provided to the above named patient, the undersigned unconditionally guarantees payment of the account charges and balance in full to DSC at discharge of the patient. DSC will process verified and assigned insurance claims as a courtesy to the patient. All uninsured balances or amounts remain payable at discharge. A late payment charge of 1.5% per month (18% per annum) will be charged on any unpaid balance not paid within 60 days of the procedure you receive at DSC. DSC's efforts to collect insurance proceeds do not affect the patient/undersigned's responsibility for any account balance. If DSC finds it necessary to refer this account for collection to enforce the obligation of the patient and/or the undersigned party(ies), the patient and/or undersigned agrees to pay any and all additional collection expenses, including DSC's reasonable Attorney's fee. The proper venue for any legal action shall be in Polk County, Florida.

10. PERSONALIZED ESTIMATE OF CHARGES. Upon a patient's request, DSC and health care providers can provide a more personalized estimate of charges and other information prior to the service; including patients with no insurance. Please note that the payments and payment ranges are an estimate of the cost that may be incurred and your actual cost may vary based on actual services rendered. You may pay less for this procedure or service at another facility or in another health care setting. Services may be provided in this health care facility by the facility as well as by other health care providers who may separately bill the patient and who may or may not participate with the same health insurers or health maintenance organizations as the facility. Patients and prospective patients may request from this facility and other health care providers a more personalized estimate of charges and other information. Patients and prospective patients should contact each health care practitioner who will provide services in the ASC to determine the health insurers and health maintenance organizations with which the health care practitioner participates as a network provider or preferred provider. Please see the providers tab on our website for more information on the providers that render services at DSC.

11. ITEMIZED STATEMENT: I have the right to request an itemized statement which will detail the specific nature of charges and expenses incurred by me (the patient) for treatment and services provided by DSC.

12. FINANCIAL ASSISTANCE POLICY. Charity care or financial assistance is not offered to patients at this time. If you do not have insurance, you are responsible for the payment of all services and fees. You will need to arrange payment with all entities separately.

I acknowledge that I have read the above numbered paragraphs 1 through 12 and fully understand and agree to their contents.

Witness to Patient/Guardian signature:

Patient/Guardian:

Print name: _____

Date: _____

Witness to Guarantor signature:

Guarantor:

Print name: _____

Date: _____