CENTER FOR
UROLOGIC SURGERY

Financial Policy/Conditions of Service Agreement

We would like to thank you for choosing Center for Urologic Surgery as your health care facility. Our primary concern is that you receive the most appropriate treatment to restore and maintain your good health. Understanding your financial responsibilities and expectations will save you worry and stress later. If you have any questions or concerns about our payment policies, please ask to speak with a financial counselor either by telephone or in person.

It is important that you read this policy carefully before you receive treatment. Insurance co-payments and deductibles are due prior to receiving treatment. Payment for all services not covered by insurance is due at the time of service.

We accept Visa, MasterCard, Discover and American Express, for your convenience. We will also bill your insurance carrier as a courtesy to you. If you are not covered by Medicare, Medicaid, or a health maintenance organization (HMO) plan contracted with the facility, you must understand the provisions set forth below:

- Your policy is an agreement between you and the insurance company. At times, even insurance companies that have a contract with the facility do not pay in a timely manner.
- If the insurance company has not paid your bill in full within 45 days, we ask that you contact them to facilitate payment.
- All charges are your responsibility whether the insurance company pays or not. Not all services are a covered benefit. Our primary contract is with you and not the insurance company.
- **You will receive a facility billing from Center for Urologic surgery for today's visit. This bill is for the center charges only. You will receive a separate bill from the physician or any other service providers. All of the charges are separate. If you have any questions before signing this agreement, please notify the admitting person you are working with.**

Disclosure of Physician Ownership:
As a prospective patient of Center for Urologic Surgery, we are pleased to inform you of the following:

1. Center for Urologic Surgery is a physician owned facility and meets the federal definition of a "physician-owned entity. The Center's ownership information is available to you or your authorized representative upon request.
2. You have the right to choose the provider of your health care services. Therefore, you have the option of using an alternative health care facility other than Center for Urologic Surgery.
3. You will not be treated differently by your physician if you choose to use an alternative health care facility. If desired, your physician can provide you with information about alternative health care facilities.

We understand that things do happen and financial problems may affect your ability to pay the bill in full. We will always do everything we can to work with you. However, we ask that you contact us as soon as possible to work out an arrangement that is satisfactory for everyone. We appreciate your faith and trust in us and thank you for the opportunity to serve your health care needs.

Notice to patients (A.R.S. 32-1401(27) (ff): Center for Urologic Surgery is a physician owned facility. Please be aware that your physician may have direct financial interest in our facility. Our services offered may be available elsewhere as advised by your physician - you do have a choice in selection of services. The law provides for the acknowledgement of your having read and understood these options by dating and signing this form. We will keep the signed original in your patient file; a copy is available to you upon request.

Note: In an event of an emergency you may be transferred to another facility for services not provided at Center for Urologic Surgery. We do not have a physician in-house twenty-four hours a day, although we do staff all ACLS prepared nursing in the post anesthesia unit and a physician is on call at all times.

Assignment and release: I authorize payment to be made directly to Center for Urologic Surgery and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my claims. If legal action becomes necessary, I agree to pay all collection fees.

Conditions of Service:

Consent to Medical and Surgical Procedures

The undersigned consents to the procedures that may be performed during this outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, radiology examination, medical and surgical treatment or procedures, anesthesia or Center services rendered for the patient under the general and special instructions of the patient's physician or surgeon.

Nursing Care

This Center provides only general duty nursing care unless upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that the service must be arranged by the patient or his/her legal representative. The Center shall in no way be responsible for failure to provide the same and is hereby released from any and all liability if said patient is not provided with such additional care.

Legal Relationship between Center and Physician

All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors with the patient and are not employees or agents of the Center. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the Center and its nursing staff to carry out the instructions of such physicians. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or Center services rendered for the patient under the general and special instructions of the physician.

Release of Information

The Center will obtain the patient's consent and authorization to release medical information, other than basic information concerning the patient, except in those circumstances when the Center is permitted or required by law to release information. The Center is authorized, without further action by or on behalf of the patient, to disclose all or any part of the patient's record to any entity, which is or may be liable to the Center, patient or any entity affiliated with patient for all or part of the Center's or Center-based physician's charges for the patient's services including, without limitation, Center or medical service companies, insurance companies, worker's compensation carriers, welfare funds, patient's employer or medical utilization review organization designated by the foregoing.

Personal Valuables

We recommend not bringing any valuable belongings with you, if you forget we will give those items to your family or representative of your choice. The center will not be responsible for valuable belongings.

Consent to Photograph

The Center is permitted to take pictures of the medical or surgical progress involving the patient and to use same for scientific, educational or research purposes.

Financial Obligations

The undersigned agrees that in return for the services to be rendered for the patient, the undersigned hereby individually obligates himself/herself to pay the account of the Center in accordance with the regular rates and terms of the Center. However, if the patient is eligible to receive benefits under a health care service plan with which this Center has contracted, the patient shall not be obligated to pay for services covered under the plan which are paid for pursuant to the contract. If any excess funds remain after payment in full of the charges for services rendered for this Center visit, the undersigned hereby authorizes the Center to apply such excess funds toward any other outstanding account(s) which the patient may have with Center for any prior services rendered and for which the undersigned is responsible. Should the patient's account become delinquent and be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law.

Assignment of Insurance or Health Plan Benefits to Center

The undersigned authorizes, whether he/she signs as agent or as patient, direct payments to the Center of any insurance benefits otherwise payable to or on behalf of the patient for this outpatient services, including emergency services, if rendered. It is agreed that payment to the Center, 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. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Assignment of Insurance of Health Plan Benefits to Center Based Physicians
The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to any Center-based physician of any insurance or health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this outpatient services, including emergency services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Medicare Patient's Release of Information
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign for the unpaid charges of the physician(s) for whom the Center is authorized to bill in connection with its services, I understand I am responsible for any remaining balance not covered by other insurances.

I Have Received the Additional Facility Specific Addendum's:
□ Patient Rights and Responsibilities
□ Information regarding Advance Directives

Financial Responsibility Agreement by Person Other than the Patient or Patient's Legal Representative
I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial
Obligations (paragraph 7) and Assignment of Insurance or Health Plan Benefits (paragraphs 8 & 9) set forth above.

Financially Responsible Party	Witness	Date

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, patient's legal representative, or is duly authorized by the patient's general agent to execute the above and accept its terms.

Date	Patient/Parent/Guardian/Conservator/Responsible Party
Time	Patient/Parent/Guardian/Conservator/Responsible Party

If other than patient, indicate relationship	Witness	Witness

Account number