FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with highest quality surgical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- Ø WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- Ø WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON A CASE-BY-CASE BASIS
- Ø FULL PAYMENT IS DUE AT TIME OF SERVICE, UNLESS ARRANGED OTHERWISE
- Ø WE ACCEPT CHECKS, OR CREDIT CARDS (VISA, MASTERCARD, AMERICAN EXPRESS)
- Ø WE ACCEPT MOST HEALTH SAVINGS ACCOUNT (HSA) PAYMENTS

Dishonored checks will be charged back to the patient's account with a service fee of $40.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred for collection.

Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, Surgery Center of Viera will bill verifiable and assignable insurance. However, you will be personally responsible for your account balance whether or not your insurance will pay for the total balance of your claims, unless you are eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that **full payment prior to services being rendered is made** by providing a credit card or personal checking account with authorization to charge that amount for the balance due if your insurance company/employee benefits plan has not paid your account in full within 90 days or has determined your claims to be your responsibility for reasons including but not limited to annual deductible, co-payment, non-covered services, ineffective coverage at time of services, lack of pre-authorization and not medically necessary.

If a patient chooses or is required to bill his/her own insurance, Surgery Center of Viera will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as self-pay.

Facility Charges

We will disclose to every patient our facility charges as clearly as practically possible before your procedure(s) if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities. As you may be aware, your insurance company requires your doctors to charge and bill their services separately from surgical facilities and hospitals. Therefore you may receive separate bills from your treating doctor, anesthesiologist, diagnostic labs, radiologist, pathologist, and others in addition to the surgical facility bills for your procedure. If you have any questions about your surgical facility bills, please direct them to us by contacting 321-751-8700.

We do not anticipate that you will require additional medical or surgical care in connection with the procedure(s) that you are requesting. Nonetheless, should you require additional medical or surgical care in the unlikely event of post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility (e.g., hospital expenses). The charges only include the stated date of services at this facility and do not include any other date of service from us or other providers and facilities.

PPO and HMO Network Participation

As you may know, you may have a choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing the highest quality care to every patient; however we have no power to change your insurance coverage or network limitations. Most health care plans or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at a lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you our participation status with your insurance plan.

At this time, we do not participate in any managed care networks other than Medicare Fee-for-Service Plans (Medicare Part B). Your health plan or insurance policy may include coverage for services you receive from out-of-network providers and facilities. However, please be aware that your plan or policy may cover a smaller portion of the cost of out-of-network provider services than it covers for the cost of in-network provider services.

As a courtesy to you, prior to your procedure we will verify your insurance coverage and obtain pre-certification, if applicable, for all services.

Please understand that your insurance carrier may take the position that insurance verification is not a guarantee of insurance payment.

Acknowledgement Regarding Disclosure of Beneficial Interest

By signing below, you acknowledge that your attending doctor(s) and/or clinic (facility) have disclosed to you at the time of initial contact and at the time of referral any significant beneficial interest they or their immediate family members might have in connection with the referral, including (A) his/her affiliation, if any, with the doctor or facility to whom you are being referred and (B) that he/she will receive, directly or indirectly, remuneration for the referral. This acknowledgement is made in connection with your right to informed consent and personal choice of doctors and facility based on the quality and safety of care, reputation of provider/facility and patient satisfaction. It is your responsibility to be knowledgeable in making decisions and exercising your rights with respect to the use of in-network or out-of-network coverage and your cost sharing responsibilities.

Doctor or Facility with significant beneficial interest: _____

By signing below, you further acknowledge that you may exercise your right of freedom of choice for the providers and facility under the in-network or out-of-network coverage as provided by your health plan, in compliance with all applicable federal and state laws, including without limitation Medicare, ERISA, PPACA and the State Business and Professions Code. You certify that you were informed of the effective alternative resources reasonably available at the time of your decision-making, and your option to use one of the alternative resources, and that you were assured by your attending physician that you will not be treated differently by the physician and his/her staff if you choose an alternative provider or entity.

By signing below, you certify that your decision to accept the referral made by your attending doctor(s) and/or clinic (facility) has been as the result of your informed choice for the quality and safety of the care that you will be expecting and receiving. Your decision is informed by, among other factors, the provider's professional reputation for providing quality and affordable healthcare that you personally expect under your health plan for out-of-network coverage.

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claims processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claims processing. You also agree to notify us immediately of any insurance inquiry or request for additional information, and will provide us with a copy of any documentation received from the insurance company or submitted to the insurance company from you.

In the event that you receive insurance payment check(s) for procedures rendered at Surgery Center of Viera, you agree to submit such insurance reimburse check(s) to our facility within five (5) business days after your receipt of insurance check(s). In the event of a failure or refusal to forward or send us the insurance reimbursement check for the treatments from this provider, all your discount arrangement will be voided and your total balance is due immediately, as there is no justification for you to keep the insurance payment for our services, as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

Indigency Discount

We may offer medical indigency discounts to uninsured (Cash-Pay) and under-insured patients. We may also waive your cost-sharing amounts, deductibles, co-insurance and co-pay based on your individual medical needs and ability to pay, on a case-by-case, non-routine, unadvertised basis for under-insured patients, and after determining in good faith that you are in financial need. Unless expressly prohibited by any specific terms of the health plan, we are fully in compliance with the terms of the health plan and applicable federal and state laws under our Corporate Indigency Policy.

Once we have determined medical indigency, we will cease collection efforts against the patient with regard to the forgiven amount. However, our cessation of collection efforts shall not constitute an agreement that the patient has no financial or legal liability for the actual total charges, nor shall it in any way impair or be construed as an abandonment of the patient's legal assignment to us of his or her right and eligibility to claim reimbursement under the patient's health care coverage. Our patient advocate collection efforts are proactive with indigency determination and subsequent claims submissions and/or appeals. Any patient balance billing is only consequential to administrative and/or judicial appeal outcomes and subject to proactive patient indigency agreement.

You may apply for medical indigency discount assistance by asking our staff. We are committed to serving you with highest quality care possible at an affordable cost. Every staff at our facility is ready to help you at all times. If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation.

I have read, understand and fully agree to this Financial Policy. I hereby authorize the referral to non-participating and out-of-network provider(s) or entities as named above.

Patient Name _____ Patient Signature (or Guardian) x_____

Name of Guardian, *if applicable* _____

Witness Name _____ Witness Signature x_____