FINANCIAL AGREEMENT

At Saratoga, Surgical Center we value the trust you place in us to provide for your care. This trust should be extended to include our billing and collection procedures.

Following your procedure, you may receive an "explanation of benefits" (EOB) from your insurance carrier. Please wait for any bill from Saratoga Center to establish if any additional amount is due. Please understand that you are entitled to an itemized bill upon your request.

Because physicians who furnish services to you during your admission are independent contractors and are not agents *or* employees of the facility, each physician (such as the anesthesiologist) who renders professional services will bill and collect independently for these services. You should expect to receive separate bills from your physician, the anesthesiologist and our facility.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize direct payment to the surgery center of any insurance benefit. I understand that I am responsible *for* any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

I agree to pay the surgery center in accordance with its regular rates and terms. I also understand that a collection agency may be used to collect on any past due balances and that should collection be necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs and filing fees.

RELEASE OF INFORMATION

I agree that the facility may disclose my protected healthy information (PHI) in compliance with HIPAA privacy provisions which may include my medical records, to any third party payer, including, but not limited to health insurers, healthcare service plans, state and federal agencies, worker´s compensation carriers or my employer in order to receive payment for services rendered. This includes appropriate release of and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other healthcare providers when necessary for my treatment and general health. The

facility has permission to disclose pertinent information to my family members, friends, or designated caregivers who may be present with me in the facility and if I am not in the facility my personal health information will not be disclosed unless I agree to it.

CONSENT TO CONTACT

I give permission for Saratoga Surgical Center to contact me via home phone, cell phone, and /or email for scheduling, follow up-care and test results, and I understand I may receive automated calls in regards to billing and payment questions.

I have read and understand this letter regarding Saratoga Surgical Center's financial policy.

Patient's Signature: ________________________________ Date: ___________________

If patient is unable to sign or is a minor, please sign below:

Legal Guardian's Signature: ______________________________ Date: _______________

Relationship to Patient: ____