FINANCIAL INFORMATION

CHARGES:

Charges for Gateway Surgery Center and your Physician are separate. The facility (Gateway Surgery Center) charges include the use of the operating / procedure room, nursing staff, medications and most supplies. Your surgeon, anesthesiologist, certified nurse anesthetist, radiologist and pathologist (if applicable) will bill you separately for their services.

CONTACTING OUR INSURANCE DEPARTMENT:

When you are scheduled for a procedure and / or surgery by your Physician's Office, we will contact your insurance carrier as a courtesy for verification of coverage.

After identifying the extent of your coverage, we will determine your financial responsibility. In most cases, we should be able to estimate the cost of your surgery / procedure beforehand. We will contact you either by phone and / or mail to make you aware of your financial responsibility. Your responsibility includes co-payments, deductibles, co-insurance, and any out of pocket amounts determined by your insurance carrier. **Any unpaid balance is due within 60 days of the date of service.** Full payment for the co-pay, deductible, and co-insurance is requested upon admission.

We make every effort to advise you of the amount prior to admission. If you have not been contacted by the Gateway Surgery Center Insurance Verification Department within 48 hours of your procedure, please call 704-920-7089.

PAYMENTS:

For your convenience, Gateway Surgery Center accepts Master Card, Visa, American Express, Discover, Personal Check (with a valid's driver's license) and cash.

Uninsured, cosmetic, and self-pay patients will be required to pay for services on or before the admission date. Patients with verified insurance are encouraged to pay their estimated portion on or before the day of their surgery/procedure.

For your convenience, pre-payment can be made prior to your visit by contacting the Insurance Verification Department at 704-920-7089.

Gateway Surgery Center will bill your insurance company as a courtesy; however, the remaining balance is the patient's responsibility. **Any unpaid balances are due within 60 days of your visit to avoid collection proceedings.**

The Center is willing to work with patients on an individual basis in regard to financial matters. Interest-free payment plans are offered through a partnership with Care Credit (800-365-8295 or www.carecredit.com). For questions or assistance in applying, please contact our Business Office at 704-920-7045.

GATEWAY
SURGERY CENTER

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

I hereby assign to and authorize payment directly to Gateway Surgery Center, LLC all benefits due to me under Medicare, Medicaid or any insurance policy providing benefits for facility charges for services rendered by the facility. I hereby assign the benefits due to me the provider of anesthesia. I authorize and instruct the insurance carrier to make payments of authorized benefits directly to anesthesia provider and hereby authorize release of all records required to act on this request. For Medicare/Medicaid: I authorize release of all records and request that payment of authorized benefits be made in my behalf to the provider of anesthesia. A photostatic copy of this agreement shall be considered as effective and valid as the original.

I irrevocably agree that the facility may disclose to the extent allowed by law, my medical and financial records to (a) any affiliate of the facility, specifically including Gateway Surgery Center, LLC and employees and agents, including entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to the facility or to me, any person or entity responsible for all or part of the facility's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred by the facility or by my physician for continued care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Center for Medicare and Medicaid Services, any government or accrediting agency, or their agents or employees.

I have received, prior to my admission, both verbal and written information on Patient Rights, Advance Directives, and disclosure of physician ownership.

All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law or by the contract between the facility and my third party payer, I HEREBY AGREE, WHETHER I AM SIGNING AS A PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE THE FACILITY AT THE USUAL CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorneys fees and collection expenses whether suit is filed or not. **Delinquent accounts and amounts (those not paid within 60 days from the date of service) may bear interest and/or a collection fee on the unpaid amount up to the maximum amount allowed by law.** I understand that the facility files for reimbursement from my insurer or other payer as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the facility.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due. Positive balances may be applied to any debts on the account.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claims for services/treatment rendered by Gateway Surgery Center. I further understand that I am financially responsible for paying for services rendered, and that it is my responsibility to provide current health insurance information to this facility.

AUTHORIZATION FOR TREATMENT: The undersigned hereby applies for outpatient treatment and/or admission of the patient to Gateway Surgery Center and gives permission to the physician in charge of the patient's care to administer treatment deemed necessary or advisable in the diagnosis and treatment of this 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 as to the result of treatment or examination in this facility. I understand that students or residents in various health-related training programs may participate in my care or observe special procedures.

NOTE: You will be billed seperately for services provided by your surgeon, anesthesiologist, radiology, cardiology, laboratory, and/or certified nurse anesthetist.

PERSONAL VALUABLES: I hereby release the facility from any responsibility for valuables, money, personal or other possessions which are not deposited with the center for safekeeping.

The use of audio and video recording devices by patients and visitors is prohibited at Gateway Ambulatory Surgery Center.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE: I acknowledge that I have received the attached Privacy Notice.

If Personal Representative's signature appears below, please describe Personal Representative's relationship to the patient.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

PATIENT _____ DATE _____

GUARANTOR_____ DATE _____

GATEWAY
SURGERY CENTER