Alliance Surgery Center Financial Policies

Alliance Surgery Center is committed to meeting the healthcare needs of all patients in a state of the art environment, with first rate staff and excellence in patient satisfaction. Alliance Surgery Center may not be a participating provider with all insurance plans, but we strive to give patients and insurers the best possible value for their healthcare dollar, providing access to superior quality care to all patients in the community, regardless of insurance type, at a cost- effective rate. Financial responsibility for patients and insurers will be calculated in accordance with any existing contractual agreements in effect on the date of service, pursuant to an assignment of benefits provided by the patient. In the absence of applicable contractual rates*, such as services rendered to patients holding insurance coverage for which the surgery center is not a participating provider, the following policies will apply.

**Contractual rates include, but are not limited to, government set fee schedules for Medicare, Medicaid, TriCare, Worker's Compensation, other government mandated fees, Third Party Agreements, direct employer or patient agreements, and Managed Care contracts.*

1. The surgery center bills both patients and health plans using the same fee schedule.
2. The surgery center does not require patient financial responsibility amounts on the date of service. Patient responsibility is determined based on the applicable patient portion of contractual rates, where a contractual agreement exists with the payor. Where contractual rates do not apply, surgery center will bill the patient for their financial portion once the claim has been processed, and appealed if necessary, and the allowable has been determined by the insurance company.
3. Upon registration, patients will sign the relevant financial documents, including the Assignment of Benefits, Authorizations & Disclosures and Acknowledgement of Financial Policies.
4. The surgery center will not waive any coinsurance, deductibles or other patient responsibility associated with services for which it has billed a health plan pursuant to an assignment, except for reasons of financial hardship; however a prompt pay discount is offered dependent upon the time of payment.
5. Patients and Insurers are eligible for an 80% prompt pay discount if the statement or claim is paid within 7 days of receipt.
6. Alliance Surgery Center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received, reviewed and processed by the insurance carrier.
7. Verification of benefits is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan in effect at the time of service. Financial obligation is based on applicable benefit levels associated with the services the surgery center provides.
8. When a health plan denies some or all of the charges, the surgery center will pursue the internal appeals process provided by the health plan, and patient responsibility will be billed after the appeal.
9. Final patient responsibility is determined based on the allowed amount of the claim as listed on the insurance company Explanation of Benefits, once processed by the insurance carrier, and the patient's applicable benefit levels.
10. Patients are informed that estimates of financial responsibility are subject to change based on procedures performed or determination of coverage, and that they remain financially obligated for any and all charges associated with services rendered.
11. Patients with no insurance coverage will be considered self-pay, and will be eligible for the 80% prompt pay discount off charges.
12. Written estimates of anticipated charges and associated financial responsibility are available upon request.
13. When patients receive payment directly from the health plan, patients must endorse and forward the payment and Explanation of Benefits to Alliance Surgery Center within 5 days of receipt to avoid additional financial liability.
14. Insurance carriers are made aware of the surgery center's discount policy through disclosure on the claim form submitted to the insurer for services rendered. Detailed financial policies are available to the insurer upon request.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advanced Directives Policy at Alliance Surgery Center and I understand that the center policy (regardless of the contents of any advance directive or instructions from a health care surrogate attorney in fact) is to initiate resuscitative measures, should an adverse event occur during my procedure. I would be transferred to the closest acute care facility for further evaluation, where further treatment or withdrawal of treatment measures already begun will be ordered in accordance with my wishes, advance directive or health care power of attorney. My agreement with this policy does not revoke or invalidate any current health care directive or health care power of attorney. Please check one of the following:

- ○ YES, I brought my Advanced Directive/Living Will/Health Care Proxy with me to place a copy in my chart as part of my medical record
- ○ YES, I have an Advanced Directive/Living Will/Health Care Proxy, but did not bring it with me
- ○ NO, I do not have an Advanced Directive/Living Will/Health Care Proxy
- ○ I wish to have information on how I can obtain an Advanced Directive/Living Will/Health Care Proxy

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to Alliance Surgery Center for any and all charges associated with the services rendered by Alliance Surgery Center, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Alliance Surgery Center verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by my insurance carrier. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay. When a health plan denies some or all of the charges, Alliance Surgery Center will pursue the internal appeals provided by the health plan, and will only bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Alliance Surgery Center may be a non-participating provider with my insurance plan, the status of which I have been informed of, and I have chosen to obtain services at this facility.
2. Alliance Surgery Center bills both patients and health plans using the same fee schedule, and my financial obligation is based on my applicable benefit levels associated with services for which Alliance Surgery Center will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, patients and health plans are offered discounts based on the time of payment, in accordance with the Alliance Surgery Center Financial Policies, a copy of which is available to me upon request, and has also been made available to my health plan.
4. I am aware of my right to request a complete written estimate of the anticipated charges, and my associated financial responsibility. I understand that the fee quoted to me for the surgery facility is an ESTIMATE only, and it is possible that I will receive a bill for any balance which I remain financially obligated to pay.
5. Fees for anesthesia services, physician fees, pathology services, laboratory fees, durable medical equipment and surgical assistants, or other services rendered which are not included in the facility global rate will be billed separately where applicable.
6. When a payment is received by the patient, directly from the health plan they have assigned to Alliance Surgery Center, patient must endorse and forward the payment and Explanation of Benefits to Alliance Surgery Center as soon as the payment is received to avoid additional financial liability.

MEDICARE CERTIFICATION AND AUTHORIZATION: Each of the undersigned certifies that the information given in applying for payment under Title XVII of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this admission, is authorized by the Social Security Administration as applicable, or their intermediaries or carriers, any information needed for any Medicare claim and to request that payment of authorized benefits be made on the patient's behalf. The Medicare program is authorized to furnish medical or other information needed for any Medicare claim and to request that payment of authorized benefits be made under Title XVII as necessary to process any complimentary coverage claim.

THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.

_____

NAME OF PATIENT

_____ _____ _____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY | RELATIONSHIP | DATE

_____ _____

WITNESS | DATE

ALLIANCE SURGERY CENTER, LLC

NOTICE OF PRIVACY PRACTICE as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Alliance Surgery Center (ASC) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about the privacy practices at ASC, please see the contact information at the end of this document.

I.HOW ASC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

ASC collects and protects the privacy of your health information. The law permits ASC to use of disclose your health information for the following purposes:

1. TREATMENT: ASC may use your health information to provide you with medical treatment or services. For example, information obtained from you by a front office personnel or nurse is necessary to determine what treatment you should receive.
2. PAYMENT: ASC may use and disclose health information about you for payment for treatment and services you receive. For example, your health information may be sent to a third party payer such as an insurance company or health plan in order for ASC to receive payment for services rendered.
3. HEALTHCARE OPERATIONS: ASC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and other to evaluate the performance of our staff, assess the quality of care and outcomes in your case and similar cases, and to determine how to continually improve the quality and effectiveness of the health care we provide.
4. INFORMATION PROVIDED TO YOU AND ON YOUR AUTHORIZATION: You may give ASC written authorization to use or disclose your health information.
5. NOTIFICATION AND COMMUNICATION WITH FAMILY: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. REQUIRED BY LAW: As required by law, ASC may use and disclose your health information. For example, ASC may disclose health information for the following reasons; judicial and administrative proceedings, to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes; to the Department of Health and Human Services to determine if we are in compliance with federal laws; or to appropriate persons in order to prevent or lessen a serious and imminent threat to the public or safety of a particular person or the general public.
7. PUBLIC HEALTH: As required by law, ASC may use and disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; to aid with disaster relief, and reporting disease or infection exposure.
8. HEALTH OVERSIGHT ACTIVITIES: ASC may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.
9. DECEASED PERSON INFORMATION AND ORGAN DONATIONS: ASC may disclose your health information to coroners, medical examiners, funeral directors, or to organizations involved in procuring, banking or transplanting organs and tissues.
10. RESEARCH: ASC may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
11. WORKER'S COMPENSATION: ASC may disclose your health information as necessary to comply with worker's compensation laws.

ALLIANCE SURGERY CENTER, LLC

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS, & DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, under any policy of insurance or other health care coverage in which the patient is a covered beneficiary, otherwise payable to me for services, treatments, therapies, including major medical, rendered or provided by the above-named health care provider, including their professional corporations or business entities, including without limitation, if applicable, pathology provider, anesthesia provider, and radiology provider by reason of this admission, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, including major medical, provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chosen action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Medicare: The undersigned parties do hereby assign, transfer and set over any and all Medicare benefits payable for health services relating to this admission to the above-named health care provider, including their professional corporations or business entities, including but not limited to, if applicable, pathology provider, anesthesia provider, and radiology provider, and hereby authorize said healthcare providers or their corporations to submit claims directly to Medicare for payment on behalf of the undersigned patient. Items not covered by Medicare will be the responsibility of the undersigned financially responsible party.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. **THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE AUTHORIZATIONS.**

_____

NAME OF PATIENT

_____ _____ _____

SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE & FINANCIALLY RESPONSIBLE PARTY | RELATIONSHIP | DATE

_____ _____

WITNESS | DATE

PATIENT LABEL HERE

PROMISSORY NOTE

PATIENT NAME: _____
ACCOUNT #: _____
DATE OF SURGERY: _____

I, _____, as a patient of ALLIANCE SURGERY CENTER, hereby agree to pay the sum of _____ ($_____) for services rendered on _____.

I understand this amount does not include any implants used in conjunction with my procedure and that I will also be responsible for the costs of these items.

I understand the estimate provided to me is an estimate only, and is subject to change based on actual procedures performed, and determination of coverage by my health plan.

Payment for these services will be in three equal payments:

Down Payment (due on the day of surgery) $ _____

Payment (due one month after surgery) $ _____

Payment (due two months after surgery) $_____

I hereby understand that an 80% prompt pay discount has been extended to me and it will remain in effect as long as I meet the payment terms under this Promissory Note. Should I default on these agreed terms, the discount will adjust and my balance owed will increase depending upon the delay of my payment(s). I also agree that I will be responsible for any and all fees associated with collection proceedings or court costs if I fail to meet my obligation under this Promissory Note.

_____ _____ _____
Signature of Patient or Responsible Party Date

_____
Mailing Address

_____ _____
Home Telephone Number Work or Cell Telephone Number

Amount Paid $_____ check cash credit card

_____
Signature of ALLIANCE SURGERY CENTER Employee Copy to Patient _____