BAY AREA PHYSICIANS SURGERY CENTER
Financial Responsibility and Release Form

FINANCIAL RESPONSIBILITY

Charges for services provided by the Bay Area Physicians Surgery Center ("the Center") cover the following components: use of the procedure room, equipment and recovery room; all supplies and medications used during your stay; and any lab tests performed at the Center. We require payment of your copay or deductible amount, if applicable, on the date of your procedure. If you are unable to pay this amount in full on the day of procedure, you will be asked to sign a promissory note detailing the payment amount and due date of the remaining balance.

Fees for physician services, procedural assistants, Anesthesiologist/Anesthetists, pathologists, laboratory work performed outside the Center and implants are separate from the Center's fee and your responsibility for payment for these fees is between you and the provider of the service.

We will submit a claim to your insurance carrier within 48 hours of receiving complete billing information. You will be notified when final action (payment, denial, etc.) by your insurance carrier has been received. If any additional funds are owed, payment will be expected within 10 days of receipt of that notice. In the event that any such amount is placed with our collection agency, you will be responsible for the collection fees, reasonable attorneys' fees and court costs. A $25.00 service charge will be added to your account for checks returned due to insufficient funds.

We file your insurance claim for you as a courtesy to you, however, our relationship is with you, not your insurance company. It is your responsibility to be knowledgeable regarding your insurance coverage and benefits. We will expect your assistance in obtaining payment from your insurance company if difficulties arise. After 90 days, with certain exceptions, the balance will become payable in full by you. In the event that any such amount is placed with our collection agency, you will be responsible for the collection fees, attorney's fees and court costs.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to the Bay Area Physicians Surgery Center of any medical and/or procedural insurance benefits otherwise payable to me or on my behalf for the procedure(s) performed at the Center, at a rate not to exceed the Center's regular charges. This assignment of benefits is valid for all insurance companies and programs including Medicare, private and group insurance, workers' compensation or other health plan payments.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Center to release medical information concerning the procedure(s) performed at the Center to the extent necessary to determine liability for payment and to obtain reimbursement. The Center may disclose portions of the medical record to any person, corporation or other entity who or which is or may be liable for any of the Center's charges. This includes, but is not limited to, insurance companies, health care service plans, and worker's compensation carriers. I authorize the Center to obtain medical information, from my physician(s), to the extent necessary to determine liability for payment or continuation of care.

CONSENT FOR OBSERVERS

I consent to the admittance of observers to the procedure room during my procedure for the purpose of advancing medical education.

CONSENT TO PHOTOGRAPH

I consent to the photographing or videotaping of my procedure as deemed necessary by my physician, for scientific or education purposes provided my identity is not revealed by the images or descriptive text accompanying them. I understand that these photographs and/or videotapes are the exclusive property of my physician.

I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS EXCEPT AS CROSSED OFF AND INITIALED. A photocopy of this authorization shall be considered as valid as the original.

____

Patient's or Guardian's Signature   Date

____

Witness   Date