Valley Surgery Center

Surgical Excellence | Compassionate Care

1. **ASSIGNMENT OF BENEFITS:** I request payment of authorized benefits be made directly to Valley Surgery Center for the use of the facility, which includes the cost of the operating room, recovery room and supplies furnished to me by Valley Surgery Center. I understand my signature requests that payment be made and authorizes the release of health records and other information related to my health care services to any health plan, including Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations in which my providers participate, and the contractors and third party administers of any of these parties, for purposes of payment or health care operations. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Valley Surgery Center. I understand that Valley Surgery Center has contracted with several health care plans. If contracted, Valley Surgery Center accepts the charge determination of the carrier as the full charge, and I am responsible for any copay, deductible, coinsurance, or non-covered services. Insurance required copays are due at the time of service. Any coinsurance and deductible are based upon the charge determination of the carrier.

2. **NON-COVERED SERVICES:** I understand that Valley Surgery Center's contracts with health care service plans relate only to items or services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care services plans not to be covered. The undersigned agrees to work with their surgeon's clinic to obtain necessary health care service plan authorizations and/or referrals prior to the procedure. I understand that if I am uninsured, or if I decide not to submit the claim to my insurance company, I will be considered "Self-Pay" and payment for the facility charges will be due prior to services being rendered.

3. **RELEASE OF INFORMATION:** I consent to the release of my health records and other information related to my health care services, created, received, and maintained by Valley Surgery Center to any person or corporation (1) which is or may be liable or under contract with Valley Surgery Center for reimbursement for services rendered, and (2) any health care provider involved in my treatment or continued care.

4. **FINANCIAL AGREEMENT:** I agree that in return of the services provided to the patient by Valley Surgery Center, I will pay all co-payments, deductibles, and other charges not covered by my health plan upon receipt of the billing statement, and/or I will make financial arrangements satisfactory to Valley Surgery Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand that I will also receive statements from my surgeon, anesthesiologist, and if applicable, physician assistant, radiologist, and pathologist, as they each bill separately for their services. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I understand that any alterations to this form, including strikethroughs, will deem the form invalid and the undersigned and/or patient will be responsible for payment in full prior to services being rendered. This agreement is valid for one year from the last dated signature.

SIGNATURE _____ DATE: ___/___/___

PRINTED NAME _____