MUNSTER SPECIALTY SURGERY CENTER, LLC.

RIGHTS AND RESPONSIBILITIES OF THE PATIENT

The Center's Patient Rights and Responsibilities are established with the expectation that observance of these rights and responsibilities will contribute to more effective patient care and greater satisfaction for the patient, his/her family, his/her physician and the facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion or culture, physical handicap, personal value and belief systems or source of payment.

Patient Rights

- Every patient has the right to be informed of his/her rights in a manner he/she can understand and to exercise these rights without being subjected to discrimination or reprisal.
- Every patient has the right to courtesy, respect, dignity, privacy responsiveness, and timely attention to his/her needs regardless of age, race, sex, national origin, religion, cultural, or physical handicap, personal values, preferences and beliefs.
- Every patient has the right and need for effective communication.
- Every patient has the right to every consideration of his/her privacy and individuality as it relates to his/her social, religious and psychological wellbeing.
- Every patient has the right to confidentiality, the right to approve or refuse the release of medical information to any individual outside the facility, except in the case of transfer to another health facility or as required by law or third-party payment contract. Every patient has the right to express grievances or complaints without fear of reprisals.
- Every patient has the right to a safe environment.
- Every patient has the right to continuity of health care. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements.
- Every patient is provided complete information regarding diagnosis, treatment and prognosis; as well as alternative treatments or procedures and the possible risks and side effects associated with treatment. If medically inadvisable to disclose to the patient such information the information is given to a person designated by the patient or to a legally authorized individual.
- Every patient has the right to be free from any act of discrimination or reprisal.
- Every patient has the right to make decisions regarding the health care that is recommended by the physician, accordingly the patient may accept or refuse any recommended medical treatment and must be informed of the consequences of his/her actions. Every patient has the right to be informed of any research or experimental projects and to refuse participation without compromise to the patient's usual care.
- Every patient has the right to appropriate treatment and care to include the assessment/managements of pain.
- Every patient has the right to an explanation and to understand facility charges related to his/her health care.
- Every patient has the right to all resuscitative measures: therefore, we will not honor Advance Directives.
- Every patient has the right to be free from all forms of abuse or harassment.
- Every patient has the right to personal privacy.
- Every patient has the right to change providers if other qualified providers are available.

MUNSTER SPECIALTY SURGERY CENTER, LLC.

Patient Responsibilities

- Patients are responsible to be honest and direct about matters that relate to them, including answering questions honestly and completely.
- Patients are responsible to provide complete and accurate past and present medical history, present complaints, past illnesses, hospitalizations, surgeries, existence of advance directive, any medications taken, including over the counter products and dietary supplements, any allergies or sensitivities, and other pertinent data to the best of their ability.
- Patients are responsible to follow the treatment plan prescribed by his/her provider and participate in his/her care. Agree to accept all care givers without regard to race, color, religion, sex, age, gender preference or handicap, or national origin.
- Patients are responsible for assuring that the financial obligations for health care rendered are paid in a timely manner.
- Patients are responsible to sign required consents and releases as needed.
- Patients are responsible for their actions if they should refuse a treatment or procedure, or if they don't follow up or understand the instructions given them by the physician or Surgery Center employees.
- Patients are responsible for keeping their procedure appointment, if they anticipate a delay or must cancel, they will notify the Surgery Center as soon as possible.
- Patients are responsible for the disposition of their valuables, as the Surgery Center does not assume the responsibility.
- Patients are responsible to be respectful of others, other people's property, and the property of the Surgery Center.
- Patients are responsible to observe safety and no smoking regulations.
- Patients are responsible for providing a responsble adult to transport him/her home from the facilty and remain with him/her for 24 hours, if required by the provider.

Complaints or Grievances

Munster Specialty Surgery Center sincerely hopes that we meet your expectations and that you are pleased with the care you receive here. We encourage your suggestions and/or feedback. We also would like to know about any concerns or complaints you may have. Please call 219-595-0789 and ask to speak with the Administrator.

If your complaint or grievance was not resolved, you may call/mail any of the below:

- Indiana Department of Health: 1-800-246-8909 or Division of LongTerm Care 2 North Meridian St, 4b Indianapolis, IN 46204
- Accreditation Association for Ambulatory Health Care: 1-847-853-6060
- Office of Medicare Beneficiary Ombudsman: http:/(www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
- Medicare: www.medicare.gov or caii1-800-MEDICARE (1-800-633-4227)

NAME OF PATIENT

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

WITNESS DATE

MUNSTER SPECIALTY 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.**

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NAME OF PATIENT

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

______________________________ ______________
WITNESS DATE

MUNSTER SPECIALTY 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.

MUNSTER SPECIALTY SURGERY CENTER LLC (MSSC) 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 MSSC, please see the contact information at the end of this document.

I. HOW MSSC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

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

1. TREATMENT: MSSC 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: MSSC 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 MSSC to receive payment for services rendered.
3. HEALTHCARE OPERATIONS: MSSC 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 MSSC 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, MSSC may use and disclose your health information. For example, MSSC 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, MSSC 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: MSSC 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: MSSC 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: MSSC may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.
11. WORKER'S COMPENSATION: MSSC may disclose your health information as necessary to comply with worker's compensation laws.
12. MARKETING: MSSC may contact you to give you information about treatments or health -related benefits and services that may be of interest to you.
13. GOVERNMENT FUNCTIONS: Specialized government functions such as protection of public officials or reporting to various branches of the armed services may require use or disclosure of your health information.
14. APPOINTMENTS: MSSC may use your information to provide appointment reminders by telephone, email or postal service.
15. BUSINESS ASSOCIATES: We work with other businesses to help MSSC operate successfully. We may disclose your health information to these business associates so that they can perform the tasks we hired them to do. Our business associates must guarantee us that they will respect the confidentiality of your personal health information.

II. WHEN MSSC MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in the Notice of Privacy Practices, MSSC will not use or disclose your health information without your written authorization.

III. YOUR HEALTH INFORMATION

1. You have the right to request restrictions on certain uses and disclosures of your health information. MSSC is not required to agree to the restrictions that you request.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. Request must be made in writing detailing the alternative methods chosen and could be applicable to fees.

3. You have the right to inspect and/or obtain a copy of your health information for a reasonable fee.
4. You have the right to request that MSSC amend your health information that is incorrect or incomplete. MSSC is not required to change your health information and will provide you information about the denial process.
5. You have the right to receive and accounting or disclosure of your health information made by MSSC except that MSSC does not have to account for the disclosure described in treatment, payment, healthcare operation, and government functions of section I of this notice. The first accounting of disclosers within a twelve-month period is free. Any additional accountings in that time frame are subject to a fee.
6. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
7. You have the right to obtain a paper copy of this Notice upon request.
8. You have the right to be notified in the event of a breach in MSSC's patient information.
9. You have the right to request that your health plan not be informed of your treatment at MSSC if you pay in full and your insurance company is not billed.

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

MSSC reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, MSSC is required by law to comply with this notice. A paper copy of this notice is available if you request a copy.

V. COMPLAINTS

If you believe that your privacy rights have been violated or if you have complaints about this Notice of Privacy Practices, contact the MSSC Administrator at:

MUNSTER SPECIALTY SURGERY CENTER, LLC
9200 CALUMET AVE. SUITE S-100
MUNSTER, IN
46321
Phone: 219-595-0789 Fax: 219-595-0748

If you are not satisfied with the manner in which MSSC handles a complaint, you may submit a formal written complaint to the Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.

______________________________ ______________________

Patient/Representative Signature Date

MUNSTER SPECIALTY SURGERY CENTER, LLC

AUTHORIZATIONS & DISCLOSURES

These AUTHORIZATIONS & DISCLOSURES MUST BE SIGNED BY THE PATIENT, or by the party legally and financially responsible for a minor or physically or mentally incapacitated patient. PLEASE READ EACH AUTHORIZATION CAREFULLY.

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize any anesthesia, medical or surgical treatment, including services rendered or provided under the general and special instructions of my attending physician, his/her assistants, and other practitioners associated, as may, in their professional judgment be deemed necessary or beneficial for the purposes of diagnosis, treatment and medical care at Munster Specialty Surgery Center, LLC. NO PROMISE, GUARANTEE OR WARRANTY HAS BEEN MADE REGARDING THE RESULTS OF ANY MEDICAL TREATMENT OR SURGICAL PROCEDURE. Any and all removed organs, or parts may be disposed of in accordance with accepted medical practices.

AUTHORIZATION T.O RELEASE MEDICAL INFORMATION FOR REIMBURSEMENT: For purpose of reimbursement, Munster Specialty Surgery Center, LLC and each attending or treating practitioner, including, but not limited to, pathology, anesthesia, radiology and laboratory providers, are hereby authorized and directed to disclose all or any part of the medical record for this admission to my employer, insurance companies, other organizations, third party payors, or agencies as may be necessary to verify or process any and all claims for insurance coverage or third-party reimbursement. I understand that such disclosures may contain information which could result in limitation or denial of insurance benefits or third-party reimbursement or which could otherwise be harmful or prejudicial to my interests.

AUTHORIZATION TO RELEASE MEDICAL AND PAYMENT INFORMATION TO SPECIFIC INDIVIDUALS: Munster Specialty Surgery Center, LLC and each attending or treating practitioner are hereby authorized and directed, during my period of this admission, to disclose medical and payment information to my spouse, children, parents, and any other person authorized to consent to treatment pursuant to current state law, concerning my health status, diagnosis, prognosis, and progress.

Munster Specialty Surgery Center, LLC is also hereby authorized and directed to disclose and discuss matters related to billing and payment after the period of admission. I do hereby release and hold Munster Specialty Surgery Center, LLC, its officers, directors, agents, employees, and all examining and treating practitioners harmless of and from any and all costs, loss damage, or liability resulting from or arising out of such disclosures.

I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care to whom medical and payment information may be released:

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_______ Please do not release my medical or payment information to any individuals.

RELEASE OF RESPONSIBILITY FOR VALUABLES: Munster Specialty Surgery Center, LLC is hereby fully released of and from any and all responsibility for loss or damage to my personal property, money, or valuables.

NOTICE OF PRIVACY PRACTICES: I am aware of my rights to privacy of personal health information, under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and am aware that a copy of these rights is available to me upon request.

RIGHTS AND RESPONSIBILITIES: I acknowledge that I have received, prior to my procedure, a copy of the Patient Rights and Responsibilities, which includes information regarding where and how I can file a grievance or complaint.

PHYSICIAN OWNERSHIP DISCLOSURE: Munster Specialty Surgery Center, LLC provides services only to patients admitted by private practitioners who are members of the Medical Staff, some of whom retain joint ownership of the surgery center. I understand I may choose another facility for the services I require and have elected to receive care at [Surgery Center].

TRANSPORTATION RELEASE: I understand that the anesthetic to be administered to me may have effects that make it hazardous for me to drive a car or otherwise travel alone to my home following my procedure and discharge. I have arranged for transportation with a responsible adult to my home and will be under the supervision of a responsible adult for 24 hours following my procedure. I understand that Munster Specialty Surgery Center, LLC will not perform my schedule procedure unless these arrangements are met and have provided Munster Specialty Surgery Center, LLC with my designated responsible party's name and phone number. The responsible party agrees to assume responsibility for accompanying and transporting the named patient to his/her home.

Responsible Party Name Signature Phone Number

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received Information about the Advanced Directives Policy at Munster Specialty Surgery Center, LLC 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 Munster Specialty Surgery Center, LLC for any and all charges associated with the services rendered by Munster Specialty Surgery Center, LLC, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Munster Specialty Surgery Center, LLC 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, Munster Specialty Surgery Center, LLC 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. Munster Specialty Surgery Center, LLC 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. Munster Specialty Surgery Center, LLC 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 Munster Specialty Surgery Center, LLC 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 [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 Munster Specialty Surgery Center, LLC, patient must endorse and forward the payment and Explanation of Benefits to Munster Specialty Surgery Center, LLC 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.

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NAME OF PATIENT

______________________________ ______________

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

______________________________ ______________

WITNESS — DATE

MUNSTER SPECIALTY SURGERY CENTER, LLC.

TO: Out of Network Members

RE: Non-participation provider

DATE OF SERVICE: ____

PATIENT: ____

Thank you for scheduling your procedure at MUNSTER SPECIALTY SURGERY CENTER, LLC.
Your physician designed this facility with you in mind, and recommends treatment here to provide you With the highest level of patient care. We are proud to serve you and are committed to meeting your healthcare needs in a state of the art environment, with a first rate staff and excellence in patient satisfaction.

Although MUNSTER SPECIALTY SURGERY CENTER LLC is not currently a participating provider with your Insurance Plan, we strive to give our patients the best possible value for their health care dollar, and we want to make it as simple as possible for you to manage the costs of services. While we cannot waive the patient responsibility required by your health plan, we are able to discount the cost of care. Our discount program allows us to provide access to superior quality to all patients in the community, regardless of insurance type, at a cost-effective rate for you, your family and your health plan.

Since we are unable to determine the exact amount your insurance will cover prior to your procedure, we request a deposit on your date of service, which will be applied to your total financial responsibility. Actual cost of care varies because the services we provide are individualized to best meet your needs. We will submit a claim to your insurance company on your behalf, and once the claim has been processed by your insurance carrier, we will send you a bill for any remaining balance, based on the amount allowed by your insurance company and your in-network benefits. Our pricing is competitive, and the total out of pocket expenses will be approximately the same, or less than what you would pay at another facility.

It is possible that the insurance payment for your visit will be sent directly to you. We ask that you please endorse the check over to the facility, and mail it, along with your Explanation of Benefits. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and make any necessary adjustments.

If you have any questions or concerns, please do not hesitate to call our billing office at 877-265-8880 between the hours of 9:00 – 5:00 Mon-Fri.

We look forward to serving you, and appreciate being your preferred choice for surgical care.

____ ____________________________

Patient/patient representative **date**

____ ____________________________

Witness **date**

Patient Label

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

Patient Name: ______________________________________ Date of Service: _________________

Thank you for choosing MUNSTER SPECIALTY SURGERY CENTER LLC as your preferred choice for surgical care. Our goal is to provide complete patient satisfaction, which includes informing you of our financial policies, your financial obligation, and what to expect after your procedure. We ask that you carefully review the below information and keep the copy provided for reference in the future. Please contact our office at any time throughout the billing process with questions or concerns.

You have indicated that you are currently covered by: _________________________________

The surgery center verifies insurance benefits and eligibility, however exact coverage and benefits cannot be determined until the claim is processed by the insurance carrier. As a courtesy to our patients, we will file medical claims with your insurance company. Final patient responsibility is determined based on the allowed amount of the claim as listed on the insurance company Explanation of Benefits, and the patient's applicable benefit levels. When patients receive payment directly from the health plan, patients must endorse and forward the payment and Explanation of benefits to the surgery center within 5 days of receipt to avoid additional financial liability.

The following is an estimation of what your will be billed for the services provided. The final bill may be higher or lower depending on the procedures actually provided on your date of service. Payments can be making via cash, check or credit card. Any amounts paid prior to the procedure will be applied to the total patient responsibility, and refunds will be issued for any overpayment amounts.

Estimated patient portion of facility fees: ______________________

Deposit paid (if applicable): _______________________

Once your statement is received, please contact our staff if you are experiencing a financial hardship, are in need of alternative payment arrangements.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility, and agree to abide by the terms of the surgery center financial policies as stated in the Authorizations & Disclosures and Billing Policies made available to me.

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NAME OF PATIENT

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SIGNATURE OF PATIENT/AURTHORIZED REPRESENTATIVE &FINANCIALLY RESPONSIBLE PARTY RELATIONSHIP DATE

____ _____________________
WITNESS DATE