UNDERSTANDING YOUR FINANCIAL RESPONSIBILITY

Name: **Date of Birth:**

Your physician has selected *M/S Surgery Center, LLC*, a state of the art Ambulatory Surgical Center (ASC) as the facility to perform your surgery/procedure. We place our highest priority on the care of our patients. We understand that the logistics of having a surgery/procedure performed can be very stressful. This sheet is provided to help you better understand your financial obligations. In most cases you may receive statements and bills from the following

PHYSICIAN: **Performing physician**
The professional fees charged by the physician who performs your surgery/procedure. He or she may be contracted with your insurance company. Your physician makes every effort to determine your financial responsibility to them, prior to your date of service. However total amounts due cannot be determined until final adjudication by your insurance company. Co-payments, Deductibles or patient portions may apply.

FACILITY FEES: **M/S Surgery Center, LLC**
You and your physician have decided to have this out-patient surgery/procedure performed in an ASC in lieu of a hospital. Just like a hospital, there are fees charged for the use of the facility. Prior to your date of service *M/S Surgery Center, LLC* will make every effort to discern what amount you will owe **the facility** at the time of service. However total amounts due cannot be determined until final adjudication by your insurance company. Co-payments, Deductibles or patient portions may apply.

ANESTHESIA: **Bill Matheis, Inc. / Mary A. Riveira Anesthesia Services**
During your surgery/procedure M/S Surgery Center, LLC has contracted with *Bill Matheis, Inc./ Mary A. Riveira Anesthesia Services* to perform the necessary anesthesia services. The anesthetists are contracted with most insurance company's your physician is providing services for. Bill Matheis, Inc. / Mary A. Riveira Anesthesia Services bill separately for their services and in certain cases, total amounts due cannot be determined until final adjudication by your insurance company. Co-payments, Deductibles or patient portions may apply.

DIAGNOSTIC TESTING: **Quest Diagnostic or Lab Corp**
In some cases an outside service is used to process specimens obtained during surgery, such as a biopsy or tissue removed from the eye. This does not apply to cataract surgery. These companies are usually contracted with your insurance, however co-payments, deductible and patient portions may apply.

PREMIUM LENS: You and your physician may decide to implant a premium *Toric or Restor Lens* during your cataract operation. The fee you pay for this lens is independent from any and all of the above listed items.

Date of Service:

Facility Co-Payment: $ _____ Other Item: $ _____ Description _____

In signing this document you agree that this is the amount due at the time service is provided. If you are unable to pay this amount, please contact our office as soon as possible.

_____ _____
Patient's Signature (or person authorized to sign for patient) Date

_____ _____
Witness Date