Harmony
SURGERY CENTER
2127 East Harmony Road, Suite 200 · Fort Collins, CO 80528
(970) 297-6300 · www.harmonyasc.com

ADMISSION AND FINANCIAL POLICY

THANK YOU for choosing the Harmony Surgery Center, LLC (HSC). We are committed to your treatment being successful. Please take a few minutes to review the following Admission and Financial policy for your surgery.

The undersigned patient, in person or by his/her duly authorized representative, requests treatment or admission to Harmony Surgery Center to receive medical, surgical or related health services and agree to the terms and conditions of the Admission and Financial policy below.

1. **Independent Contractors**: I understand that all Medical Staff physicians and other Ambulatory Surgery Center (ASC) contracted professionals furnishing services are independent contractors, and are not agents or employees of the ASC. As such, the ASC is not liable for their actions or omissions. These independent contractors may bill separately for their services.

2. **Consent for Service**: I consent, voluntarily, to the rendering of healthcare services by the HSC's employees and/or independent contractors. The scope of healthcare services may include routine ASC services, diagnostic procedures, medical treatment and other ASC care and services as my attending physician(s) or others holding clinical privileges at the ASC deem necessary. I further understand that I have the right to discuss proposed procedures and treatments with my physician, and to consent to, or refuse such procedures or treatments.

3. **Personal Valuables**: The ASC is not liable for any loss or damages to any money, jewelry, glasses, dentures, documents or other articles of unusual value, which I choose to bring to the facility.

4. **Notice of Privacy Practices and Patient Rights:** By signing below I acknowledge that I have been offered a copy of the Patient Rights and Responsibilities and the ASC's Notice of Privacy Practices. I give my consent to the ASC to use and disclose my Protected Health Information ("PHI") as described in the Notice and as allowed by law.

5. **Exposure:** In case of being the source of a blood or body fluids exposure, I understand that I am giving my consent to be tested for Hepatitis and HIV. I understand the results of this test will be kept confidential and will be used to determine appropriate treatment for the individuals exposed. If I have an interest in receiving a copy of the results I can contact University of Colorado Health Medical Records at 970-495-7343. I understand I am responsible for contacting my primary care physician for follow up of these results. I understand that a positive result will be reported to the Colorado Department of Health along with my name, address, sex and date of birth, as required by law.

6. **Assignment of Insurance Benefits:** If I am entitled to benefits of any type whatsoever arising out of any insurance policy or public entitlement insuring me or any other party liable to me, such benefits are hereby assigned to the ASC for services rendered.

7. **Waiver of Responsibility for Discharge**: In the event I should leave the ASC against the advice or direction of the facility or attending physician, I hereby release the ASC and independent contractor from all responsibility for any adverse effects that may result from such discharge, and will not hold or attempt to hold the ASC and/or independent contractor liable for resultant loss, damages, injury, or disability.

I understand that billing insurance or other benefits is a service only and is not a guarantee of payment. If the Payer does not pay within forty-five (45) days of billing, I shall be financially responsible for the full amount of the bill. I will also promptly furnish, complete and sign any forms that may be necessary to obtain reimbursement from a Payer to the ASC for services rendered.

I hereby give my expressed consent to allow Harmony Surgery Center to be one of my designated representatives to represent me in an external review of a denial of benefits by my insurance company. I will cooperate with HSC in any such review.

8. **Patient Insurance Coverage Requirements**: If the ASC is a provider of my insurance, the ASC will bill my insurance and collect only the patient responsibility. IT IS MY RESPONSIBILITY TO INFORM THE ASC OF ANY CHANGES WITHIN MY INSURANCE PLAN AND/OR COVERAGE. If the ASC is not provided accurate information at time of service, I may be responsible for payment in full for all services provided. Any condition of payment required by a Payer, such as a second opinion, pre-authorizations, and admission notification and/or emergency treatment notification shall be my obligation, and failure to perform a condition of payment shall be my responsibility and shall in no way limit my financial responsibility to the ASC for the full amount of the bill.

9. **Financial Agreement**: I agree that my insurance coverage is a contract between myself and my insurance company. HSC is not responsible for services denied by my insurance company. I agree to pay for services rendered at the ASC, which is not paid or excluded by any other Payer, in accordance with the regular rates and financial policy of the ASC. It is understood and agreed that my account is due and payable upon billing. Should my account be referred to an attorney for collections, I agree to pay reasonable attorney fees, costs and collection expenses, including the attorney fees incurred by the collection agency. I understand that I will receive notification of any overpayments made and I will be refunded my overpayment once a correct claim has been processed unless I have outstanding balances on other dates of service.

10. **Self-Pay/Patient Balances**: I understand that if I do not have insurance coverage I am responsible for the full amount billed for my date of service. The HSC's Financial Policy requires all balances be paid in full no later than 120 days (4 months) after the initial billing statement. If I experience circumstances beyond my control, I can contact the Business Office at 297-6429, and they will be happy to make reasonable payment arrangements with me.

11. **Cosmetic Cases**: HSC requires all Cosmetic cases to be paid in full prior to or on your date of surgery.

12. **Facility Estimate**: I understand that if I received a facility estimate prior to my procedure, I realize that it was only an estimate of my financial responsibility, not a final bill for my date of service.

13. By providing our facility with your landline or cell phone number(s), you give express authorization to contact you at those numbers in regard to this date of service. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology. Providing your cell phone number(s) is not a condition of receiving our services.

14. Patients staying overnight will be asked to create a password to authorize the release of medical information to others of their choosing. I authorize appropriate Harmony Surgery Center workforce members to release information from my medical record to individuals with the identified password.

15. Harmony Surgery Center provides services for off-site transfers. An off-site transfer will occur in case of the need for a higher level of care than is provided at the Center. Transfer agreements are maintained with Medical Center of the Rockies and Poudre Valley Hospital. The receiving facility will provide the level of care necessary to meet the needs of the patient. If transfer of care is needed, patients will be transported via ambulance. Cost of the transfer will be determined by individual medical insurance coverage. For information regarding monetary responsibilities, please contact your insurance company. All transfer-associated costs will be at the responsibility of the individual insurance coverage and/or patient.

I certify that I have read this Admission and Financial Policy, and that the information given by me in regards to my admission is correct and I have access to a copy of it. I understand that no agent or employee at HSC is authorized to change or eliminate any provision of this Agreement. No alterations, additions or deletions shall change the obligation to which I have agreed.

ADVANCE NOTICE FORM

Your surgeon has scheduled a surgery or procedure for you at our facility. We consider it an honor and privilege that you have entrusted your care to the nurses and staff at our facility, and appreciate the opportunity that you have given us to serve you.

New federal guidelines mandate that we appropriately advise you of your patient rights, advanced directives and possible physician financial interest in Harmony Surgery Center in advance of your surgery or procedure.

I have read the brochure entitled "Patient Rights, Responsibilities and Complaints" and understand the information.

PHYSICIAN FINANCIAL INTERESTS

Harmony Surgery Center is an LLC operating as an Ambulatory Surgery Center and Convalescence Center under the laws of the State of Colorado. The following physicians and entities have a financial interest in this facility:

A. Mark Boustred, MD; Michael Brown, DO; Thomas G. Chiavetta, MD; Craig R. Clear, MD; Rand F. Compton, MD; James Dickinson, MD; Thomas Dowgin, MD; Rebecca Dunphy, MD; Mark Durkan, MD; George Girardi, MD; Benjamin Girdler, MD; Denis Gonyon, Jr., MD; Daniel Hatch, DPM; Daniel Hampton, MD; Joseph X. Jenkins, MD; Nicole Kershner, MD; Chad Knutsen, DPM; Andrew Norris, MD; Stefan Pettine, MD; Robert R. Quaid, MD; Matthew Robertson, MD; Michael Roller, MD; Robert Schulte, DPM; Timothy Soper, MD; Christopher Tsoi, MD; Benjamin Wisner, MD; Stephen Wold, MD; & Poudre Valley Health Care, Inc.

By providing us with your email, landline or cell phone number(s), you give express authorization to be contacted at that email, and those numbers, as well as authorize such contact by our agents and assigns in regard to this date of service. This express authorization also applies to any email, landline or cell phone number(s) you may acquire in the future. Methods of contact may include emails, prerecorded/artificial voice messages and/or use of an automatic dialing device. I/We have read this disclosure and agree that we may be contacted as described above.

Date:______________________________ Authorized Signature:______________________________________

Receptionist Initials:____________________ Relationship:____