NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I have received information about the Advance Directives Policy at Advanced Surgical Center of Sunset Hills 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 Advance 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 Advance Directive/Living Will/Health Care Proxy, but did not bring it with me
- ◯ NO, I do not have an Advance Directive/Living Will/Health Care Proxy
- ◯ I wish to have information on how I can obtain an Advance Directive/Living Will/Health Care Proxy

NOTICE OF FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to Advanced Surgical Center of Sunset Hills for any and all charges associated with the services rendered by Advanced Surgical Center of Sunset Hills, whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Advanced Surgical Center of Sunset Hills 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, Advanced Surgical Center of Sunset Hills will pursue the internal appeals provided by the health plan, and will bill the patient for any amounts which remain outstanding after the appeals are exhausted. I further acknowledge:

1. Advanced Surgical Center of Sunset Hills 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. Advanced Surgical Center of Sunset Hills 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 Advanced Surgical Center of Sunset Hills will bill my health plan pursuant to an assignment.
3. Where contractual rates do not apply, patients and health plans are offered discounts, in accordance with the Advanced Surgical Center of Sunset Hills 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 Advanced Surgical Center of Sunset Hills, patient must endorse and forward the payment and Explanation of Benefits to Advanced Surgical Center of Sunset Hills 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.

NAME OF PATIENT

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

WITNESS | DATE