ANESTHESIA SERVICES

PATIENT CONSENT/FINANCIAL AGREEMENT

Financial Agreement: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the anesthesia charges (including but not limited to insurance companies, health care services plans, or workers compensation carriers).

Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, I shall be individually responsible to pay Amsurg Tampa Bay Anesthesia Service for all such services, at Amsurg Tampa Bay Anesthesia services regular rates and term should my insurance company deny payment. I shall also be responsible for any deductibles or co-pays owed at the time of service. Should this account be referred to collection to any attorney or collection agency, I shall pay all attorney's fees and collection expenses in connection therewith, if the patient's account is delinquent. I shall be responsible for paying center interest on the full outstanding balance at the minimum rate allowed by laws.

I hereby certify that the information given by me in the applying for payment under XVIII and XIX of the Social Security Act or by any other payor is correct. I assign to Amsurg Tampa Bay Anesthesia Services, all benefits due me under the terms of said policies and programs but not to exceed the company's regular changes for similar services.

The consent is valid for one year after the initial signature or until charges have been made in my insurance coverage of the attending physician.

X_____________________________________
Full Signature of Patient/Guardian

X_____________________________________
Full Signature of Witness

X_____________________________________
Date

PLACE PATIENT LABEL HERE