WEST BANK
SURGERY CENTER, LLC

General Consents / Financial Responsibility

Responsibility for Payment

- The patient is responsible for all charges incurred at the Surgery Center. A bill from the Surgery Center for the use of the Surgery Center will be sent to the patient and/or the patient's responsible party. The charges on the bill cover the use of the facilities. These charges do not include any professional fees, or associated fees for any additional services used, to include but not limited to: anesthesia professional services; pathology; radiology; laboratory; or pre-operative testing fees. I recognize I will receive a separate bill for these services.

- If you have health insurance, we will help you receive the benefits afforded to you by filing a claim for you. If you have a deductible, co-pay, or co-insurance, payment of such amounts must be made prior to the surgery or procedure. You are expected to follow the rules of your health insurance provider in obtaining pre-authorization or referrals. Any non-covered amounts will be the patient's responsibility and will be billed to the patient in accordance with the terms of the patient's coverage/contract.

- If you do not have health insurance, payment arrangements must be made prior to the surgery or procedure. Please request a price quote for charges based on your surgery/procedure. These quotes are based on averages and may vary significantly from the actual charges because every patient's surgery/procedure is different. These quotes will not include any physician fees or services (e.g., physician/surgeon, anesthesia provider), nor any pathology or laboratory charges.

- Any returned check fees and/or collection fees will be the patient's responsibility.

_____ (initial)

Disclosure Agreement

- I acknowledge that my physician and I have discussed the surgery/procedure involved and that this Surgery Center is merely a locale for that surgery/procedure. I understand the physician may have an investment interest in the Surgery Center but does not act on behalf of the Surgery Center. I was informed of this potential investment interest prior to the day of my procedure. I understand that I may choose to have the surgery/procedure performed at another Surgery Center, but I voluntarily consent to the performance of the surgery/procedure at this Surgery Center.

_____ (initial)

- I acknowledge and understand that the physicians and other independent health care providers who provide the medical services, including, but not limited to, anesthesia services, pathology and radiology services, are not employees or agents of the Surgery Center but are independent contractors. I acknowledge and understand that the Surgery Center may delegate to these independent health care providers those services physicians or independent contractors normally provide. Any questions relating to the care that my physician or independent health care provider has given or ordered should be directed to him or her. I hereby expressly agree to hold harmless West Bank Surgery Center regarding the services to be performed by these independent health care providers.

_____ (initial)

- By discharging West Bank Surgery Center of its duties regarding services to be performed by the independent health care providers, I understand that I am giving up my right to hold West Bank Surgery Center liable for any and all potential negligence of the independent health care providers. This, however, does not release West Bank Surgery Center from responsibility for any direct acts of negligence by its employees.

_____ (initial)

Observers

- I acknowledge that understand that at my physician's discretion, there may be observers present during my procedure. These observers may include, but are not strictly limited to, medical device/supply vendor representatives, medical, nursing or other allied health students, and equipment repair technicians as needed. I understand that any and all personnel present during my procedure are bound to strict confidentiality requirements.

Personal Property

- I understand and acknowledge that I was instructed that I should not bring valuables to the Surgery Center and that the Surgery Center will not be responsible for the loss, destruction or theft of my personal property. I assume full responsibility for all my personal property, including but not limited to my clothing, money, jewelry, glasses, dentures, hearing aids or other personal items and release the Surgery Center from responsibility and liability for such personal items and valuables.

Photography

- I hereby consent to the use of photography/recording of my surgery for educational purposes at my surgeon's discretion and release West Bank Surgery Center from all liability from claims of any kind for the taking and use of these photos/recordings.

Pregnancy

- I understand that if I am pregnant or if there is any possibility that I may be pregnant, I must inform West Bank Surgery Center immediately since there could be harm to my child or myself.

Blood Testing

- I hereby consent to have my blood tested if my physician should deem it necessary. The test is to determine whether or not I have antibodies in my blood to the hepatitis B virus (HBV) and to the human immunodeficiency virus (HIV), which is the probable causative agent for AIDS. I understand withdrawing blood from my vein starts this test and a substance is then used to test the blood. I understand that the blood sample may be drawn prior to my surgery, during surgery or after the procedure is performed.

Hospitalization

- I understand that should it become necessary for me to be hospitalized during my stay at West Bank Surgery Center, the decision as to the hospital I will be transferred to will be the decision of my physician and not the decision of West Bank Surgery Center. I hereby release West bank Surgery Center from any and all responsibility for care rendered to me at another healthcare facility.

The undersigned certifies that he/she has read (or had read to them) the foregoing and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

_____	_____
PRINT Patient Name	Date/Time
_____	_____
Patient Signature	Date/Time
_____	_____
Patient Representative Signature / Relationship	Date/Time
_____	_____
Witness Signature	Date/Time