CANYON SURGICAL CENTER

FINANCIAL AGREEMENT

Financial Agreement:

I agree that payment for all charges incurred is the primary responsibility of the patient or the patient's responsibility party. I authorize Canyon Pain Surgery Center, LLC (CPSC) or its agent to verify the patient's employment or insurance coverage. If the account is sent to a collection agency, the patient shall pay, in addition to all sums due to CPSC, reasonable collections fee. If any of my checks are returned by my bank, I understand that I will be charged an additional fee at the prevailing rate at that time.

The patient is responsible for charges incurred at CPSC. A bill from CPSC for the use of the facility will be sent to the patient and/or the patient's responsibility party, the bill charges cover the cost of the service rendered, these charges do not include any professional physician's fees, Pathology, etc., and any pre-operative testing fees.

If you have insurance, CPSC will file a claim for you as a courtesy. A copy of your insurance card and photo identification is needed prior to the day of surgery. If you have a deductible, co-pay, or co-insurance due, payment arrangements must be made prior to surgery.

For insurance patients:

I understand that if a quote is provided with a facility fee, this is subject to change based on medical necessity and if additional procedures are performed. Your insurance makes the final determination of patient liability for all claims. Our amount is only an estimate.

For Self-Pay patients:

I Understand that payment is due prior to surgery day. If additional procedures are performed outside the original scheduled appointment, we will contact you for the balance.

Acknowledgment:

I acknowledge receipt of the "Notice of Privacy Practices" brochure with Patient Rights and Responsibilities and Safety Notice, the undersigned certifies that he/she read the foregoing, received a copy thereof, and is patient, the patient's legal representative, or is dully authorized by the patient as the patient's general agent to execute the above and accept its terms. I also understand that a photocopy of this is valid as the original.

_____	_____	_____	_____
Patient or Authorized Person Signature	Printed Name	Relationship (if not patient)	Date & Time

_____	_____	_____	_____
Witness Signature	Printed Name	Date	Time