ADMISSION AND FINANCIAL POLICY

The undersigned patient, in person or by their duly authorized health care agent, requests admission to Lakeside Dental Surgery Center, to receive medical/dental 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/Dental Staff providers 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 LDSC'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 provider(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 provider, and to consent to, or refuse such procedures or treatments.

3. **Personal Valuables**: The ASC is not liable for any loss or damage 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 Jessica Generazio-Green, Facility Administrator at (904)395-4840. I understand I am responsible for contacting my primary care provider for follow up of these results. I understand that a positive result will be reported to the FL 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 provider, 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.

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's 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 with accurate information at the 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.

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 thirty (30) 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 Lakeside Dental 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 LDSC in any such review.

9. **Financial Agreement**: I agree that my insurance coverage is a contract between myself and my insurance company. LDSC is not responsible for services denied by my insurance company. I agree to pay for services rendered at the ASC, which are not paid for 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 any overpayments made will be refunded upon my request as long as my overpayment is accurate 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 LDSC's Financial Policy requires all balances to be paid in full no later than 90 days (3 months) after the initial billing statement. If I experience circumstances beyond my control, I can contact the Facility Billing Department at (904) 395-7772, and they will be happy to make reasonable payment arrangements with me.

11. **Cosmetic Cases**: LDSC 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.

How to obtain an estimate of charges

A patient may obtain an estimate of charges included on the statewide 20 most common outpatient procedures list by contacting our Facility Billing Department at (904) 395-7772. Upon request from the patient, the information will be provided in writing within 3 business days.

For Dental, these codes are: D0160, D0240, D0272, D1120, D1206, D1208, D1351, D1510, D1515, D2330, D2331, D2391, D2930, D2932, D2933, D3220, D7140, D9420, D9971 and D7960.

13. By providing our facility with your landline or cell phone number(s), you give authorization to contact you at those numbers regarding this service date. 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. Lakeside Dental Surgery Center does not provide 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 by calling 911 services.

15. How to Dispute a bill: A patient may dispute a charge by contacting our Facility Billing Department at (904) 395-7772. If a dispute cannot be resolved by financial services, the patient may submit a written appeal to Lakeside Dental Surgery Center. The patient has 30 days from the original statement date to dispute the charge.

I certify that I have read this Admission and Financial Policy, and that the information I give about my admission is correct, and I have access to a copy of it. I understand that no agent or employee at LDSC 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.

By signing below, I acknowledge I have read and understand the Admission and Financial Policy. I have had the opportunity to ask questions and more information can be provided to me by request.

Patient or Health Care Agent

______________________________________ ________________________

Signature Date

______________________________________ ________________________

Witness Date