<u>MNH Surgical Center</u>

Disclosure of Ownership

MNH Surgical Center strives to provide Quality Care . In order to provide personal care and make it more convenient for you , your physician helped establish an Outpatient Surgery Center , and has an ownership interest in the center .

You may choose to have your procedure at MNH Surgical Center to which you were referred , or another facility of your choice . Other alternatives are :

1. Florida Hospital -Altamonte
   E Altamonte Drive
   Altamonte Springs , FL
   (407) –830-4321

2. South Seminole Hospital
   555 East SR 434
   Longwood , Fl
   (407)-831-0945

Explanation of Charges / Financial Consent

The following facility charges are a <u>Rough Estimate</u> of the base procedure **.** Exact charges are not determined until the procedure is completed and all aspects are included (such as additional biopsies , polyp removal , Dilatation ….etc) .
MNH Surgical Center is contracted with most insurance companies , and usually your responsibility is constituted of your Deductible and / or Co-pay .

Procedure Description : ___________________________ Standard Charge : $__________
Base procedure
Primary Ins : ___________________ Coverage : _________ % of contracted amount .
Secondary Ins : _________________ Coverage : _________ % of contracted amount
Patient responsibility = Deductible and / or Co-pay ($ ___________)
Indicate amount if known

Explanation of charges shown above is based on verification of benefits by your insurance company . Verification of benefits is not a guarantee for payment by your insurance company . Final payment is the responsibility of the account guarantor .

In addition to the facility fee , other bills also may be incurred by the following providers, who will bill your insurance company separately .

1. Physician / Surgeon performing the procedure (Physicians Professional Fees)
2. Pathology Lab (If biopsies were sent out to the lab for analysis)

In the event MNH Surgical Center should find it necessary to refer this matter to a collection agency , or other party for recovering payments due hereunder , all costs incurred with such collection will be the responsibility of the patient , his / her authorized representative , guarantor or designee .

Signature : ___________________________ Date : __________
Patient / Guardian

Signature : ___________________________ Date : __________
MNH Staff Member