CONDITIONS OF ADMISSION
TO
VAIL VALLEY SURGERY CENTER LLC

1. CONSENT TO MEDICAL AND/OR SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed during this surgery center visit, which may include, but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment, anesthesia, transfusion, physical therapy and rehabilitation services, or other services rendered to the patient under the general and special instruction of the patients physician or surgeon.

2. RELEASE OF INFORMATION: The ambulatory surgery center shall not release information, other than basic information concerning the patient without the patients consent and his/her written authorization to release such information, except in those circumstances where the ambulatory surgery center is permitted or required by law to release information without the patients consent or authorization.
The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, the surgery center may disclose portions of the patients record including his/her medical record, to any person or entity which is or may be liable for all or any portion of the hospitals charges, including but not limited to government agencies (e.g., Medicare, Medicaid), insurance companies, health care service plans, or workers compensation carriers. Special permission is needed to release this information when the patient is being treated for alcohol or drug abuse.

3. FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the surgery center in accordance with the regular rates and terms of the center. The undersigned agrees to be financially responsible for any services deemed non-covered by insurance or elected by the patient. Should the account be referred to any attorney or collection agency for collection, the undersigned shall pay all actual attorneys fees and collection expenses. All delinquent accounts may bear the highest interest rate allowed by law.

4. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as an agent or as patient direct payment to the center of any insurance or other applicable (eg Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for this ambulatory surgery center services, including emergency services if rendered, at a rate not to exceed the surgery center's regular charges. It is agreed that payment to the center pursuant to the extent of such payment. Any precertification of insurance benefits is the patient's sole responsibility. The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patients of all services furnished by or in the Vail Valley Surgery Center LLC. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract by law.

5. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR PAYMENT OF INSURANCE BENEFITS:

Physicians/Group_____VVSC[1]_____**Patients Name**_____ **I hereby**
Authorize the release of all information from the above named patients medical record that may be necessary to make reimbursement or payment for any or all the services rendered by the Physician or Group identified above. I hereby authorize reimbursement or payment for any or all the services rendered by the Physician or Group identified above. I hereby authorize my insurer or any third party responsible for the payment of covered medical/surgical benefits on my behalf to make payment directly to the Physician or Group identified above.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patients legal representative, or is duly authorized by the patient as the patients general agent to execute this document and accept and agree to its terms.

_____ _____
Date Patient/Parent/Guardian/Conservator/Agent

_____
Time If other than patient, indicate relationship

_____
Witness

Financial Party Agreement by Person other than the Patient or the Patient's Legal Representative:
I agree to accept all financial responsibility for services rendered to the Patient and to accept
the terms of the Financial Agreement and Assignment of Insurance Benefits provision enumerated above.

_____
Financial Responsibility Party

_____ Patient receipt of notification of privacy practices.

VVSC01 03/10