SELF PAY AGREEMENT
Weston Outpatient Surgical Center

2229 N. Commerce Pkwy., Weston, FL 33326

Procedure(s): _____

Total Self-Pay Rate: $_____

Facility Rate: $ _____

Anesthesia Rate: $ _____

The above stated cost is the Self Pay Rate for your scheduled procedure(s). Weston Outpatient Surgical Center will provide the use of the operating room facilities, which includes medical equipment, standard supplies, standard medications and nursing care. **The self-pay cost does not include any lab work that may be required. You will be billed separately if pathology services are needed; as well as additional anesthesiologist time not previously estimated.**

Patient Name _____

Patient Acct # _____

Date and Time of Surgery _____

Physician _____

- I understand that the Self Pay Rate that I have been granted is only for patients who will not be filing a claim with their insurance company**.**
- I understand that this agreement along with a payment receipt will serve as the only itemized receipt I will receive for my scheduled procedure. ***No additional itemized statements, documentation or coding information will be issued to patients who are granted self-pay rates.**

_____ _____

Patient Signature Center Representative

_____ _____

Date Date

Patient Paid to WOSC $_____

Patient Paid to GFA $_____

PLEASE CIRCLE FORM OF PAYMENT

VISA MASTERCARD DISCOVER AMEX CASH CHECK#_____