WESTON
Outpatient Surgical Center

Self-Pay Rate Request
Fax back to (954) 703-3151

Date: _____ PLEASE ATTACH SCHEDULING REQUEST FORM

Requested by: _____ Phone: _____ Physician: _____

Patient Name: _____ Date of Service: _____ CPT Code(s): _____

Procedure Description: _____

Expected Length of Procedure: _____ D.O.B. _____

Equipment Needed? Please check:

☐ C-Arm ☐ Laser, Type: _____ ☐ Arthroscope ☐ Endoscope ☐ Laparoscope ☐ Other: _____

***Implants and/or Special Supplies Needed for Case (screws, fixators, pain pump, bone, allograft, etc.):

_____

_____

This estimate is based on information given by surgeon's office. Any additional minutes used in O.R. will also be an additional fee to the patient after surgery for anesthesia.

Any implants/special supply items used for case but not listed will be provided at an additional cost to the patient**.**

$			
Quoted Rate * **	**Quoted By**	**Approved By**	**Date**