STERLING
SURGICAL HOSPITAL
The Surgery You Need in the Setting You Want

Patient Label

YPS Anesthesia

1. Financial Responsibility

The undersigned agrees, that in return for the services to be rendered for the patient, the undersigned individually obligates himself/herself to pay the account of YPS Anesthesia in accordance with the regular rates and terms of YPS Anesthesia. Should the patient's account become delinquent a nd be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses.

2. Assignment of Insurance or Health Plan Benefits

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to YPS Anesthesia of any insurance or health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this hospitalization or for outpatient services, including emergency services if rendered, at a rate not to exceed our regular charges. It is agreed that payment to YPS Anesthesia pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement.

3. Release of Information/Medical Records

I hereby consent to authorize YPS Anesthesia to release information contained in any financial records and/or medical records, including but not limited to diagnosis and treatment to (1) Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors; (2) Medicare; (3) Medicaid; (4) any other person or entity that may be responsible for paying or processing payment for any portion of my bill; (5) to any person or entity affiliated with or representing YPS Anesthesia and any practitioner providing medical goods and services to patient for the purpose of administration, billing and quality and risk management. This consent and authorization applies to financial and/or medical records created in the course of and relating to this or subsequent related services. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred for treatment with YPS Anesthesia. The consent to release medical information is subject to revocation in writing any time, except to the extent that action has been taken.

_____
Patient Name

_____
Financially responsible party signature

_____ _____
Date Time