SURGERY PARTNERS

Todays Date: _____

Account Number: _____

Surgery Partners Ambulatory Surgery Center is an out of network facility with my insurance company,

_____.
(Name of Insurance Company)

I understand that as a courtesy to all patients who are out of network, Surgery Partners Ambulatory Surgery Center has agreed to honor my in-network benefit's rates as payment in full.

I am aware my insurance company may send me payment for the service provided at the facility. Under Florida law, I agree to endorse this insurance check to the facility within 30 days of receipt. Failure to do so could result in my account being forwarded to the Credit Bureau for the payment in full.

_____ _____
Patient Signature Date

_____ _____
Witness Signature *(Front Desk)* Date