POINT MEADOWS SURGERY CENTER

INSURANCE COMPANY PAYMENT

I have been advised that Point Meadows Surgery will bill my insurance company directly for my procedure(s).

I have been further advised that the payment may be sent to me by my insurance company.

By signing below, I affirm and attest that I am in no way entitled to this reimbursement for my procedures, and I understand that this money is intended to pay Point Meadows Surgery Center. Accordingly, it is hereby understood and agreed that I have no right, implied or otherwise, to said funds, as they do not belong to me, and/or the insured party, and are intended to pay for my care and procedure(s) which are being performed with my informed consent.

Furthermore, in the event that I receive a check(s) from the responsible insurance company as payment for my procedure(s) or the insured's procedure(s) I will immediately, or within 48 hours, contact Point Meadows Surgery Center about the check, and return these funds to the appropriate parties. I understand that I am ultimately responsible for all medical bills if my insurance company fails to pay, and I will assist Point Meadows Surgery any entity with collection of any funds. In the event that a check or checks are made payable to me or the insured, and is/are received by the facility, I hereby grant the facility the express permission, and a limited power of attorney solely and exclusively for the purpose of endorsing said checks which will obviate the necessity of returning to the facility with the express intent of endorsing said checks to the facility/provider(s).

If either part defaults in the performance of any of the terms, provisions, covenants and conditions and by reason thereof, the other part employees the services of an attorney to enforce performance of the covenants, or to perform any service based upon defaults, regardless of the initiation of court proceedings, then in any of said events, the prevailing party shall be entitled to recover from the non-prevailing party, all of the prevailing party's reasonable attorney's fees and all expenses and costs incurred by the prevailing party pertaining thereto (including costs and fees relating to any appeal) and in the enforcement of any remedy.

By signing below, I agree that the sole and exclusive venue for any litigation arising from or related to this agreement shall be in the Court of Duval County.

Patient Signature:_____ Date: _____