NEW TAMPA SURGERY CENTER

In an effort to promote health care price and quality transparency to enable consumers to make informed choices regarding health care treatment, our team can accommodate requests made for any of the following by calling the facility:

- Personalized Financial Estimate: To view information on payments made to the facility for defined service bundles and procedures, you can visit the Agency for Healthcare Administration's pricing website at http://pricing.floridahealthfinder.gov. Service bundle information is a non-personalized estimate of costs that may be incurred by the patient or the prospective patient for the anticipated services; the actual costs charged will be based on the services actually provided to each patient. Upon a patient's, or a prospective patient's request, the facility can provide a more personalized estimate of charges and other information prior to the service, including patients with no insurance. Services may be provided by the facility as well as by other health care providers who may separately bill; such health care providers may or may not participate with the same health insurers or HMOs as the facility. Patients and prospective patients should contact each health care practitioner who will provide services to the patient in the facility to determine the health insurers and HMOs with which the health care practitioner participates as a network provider or preferred provider. Patients and prospective patients may also ask the providers for a personalized estimate of charges and for information regarding their billing practices. These requests may be made by contacting the provider at the contact information listed on the Meet Our Physicians tab of our website.
- Budget Agreement: The facility provides options to assist a patient in setting up a payment plan for out-of-pocket costs like co-insurance, deductibles, etc.
- Financial Hardship/Charity Application: Patients can apply for financial hardship when they meet the following criteria:

    1. Income level is based on income levels of the full household in which the patient resides.
    2. Household income must fall within the Financial Hardship tiered pricing grid.
    3. Patient must complete and sign the Financial Verification Form.
    4. Patient must provide proof of all household income.

- Indigent Care: If a patient meets the above criteria, he/she may file an application by completing and submitting the Financial Verification Form available at the facility. The application for discounted care or indigent care is to be kept confidential. Discounted Care and indigent care is generally for people who do not have other financial resources available, such as insurance, government programs or regular income. The facility's decision to provide indigent care does not affect the patient's financial obligation to the physician or other health care providers. The Business Office Manager/the ASC Director, the Facility Administrator, and/or the Regional Vice President will review the application for indigent care. Approval or disapproval of the application will take place and the patient notified before the case is scheduled. Written notice including the level of discount allowed will be sent to the patient. Disapproval will include the reason for denial. If the outstanding balance is not paid within the payment terms, the facility has the right to cancel any indigent care discount and assign unpaid balances to collections.

- Payment Plans and Discounts Policy: If a patient does not meet the above criteria but has limited financial means, limited immediate financial capacity, or has no third-party coverage (insurance, governmental programs, worker's compensation, motor vehicle accident coverage, etc.); he/she may file an application by completing and submitting the Financial Verification Form available at the facility. The application for discounted care is to be kept confidential. The facility's decision to provide discounted care does not affect the patient's financial obligation to the physician or other health care providers. The Business Office Manager/the ASC Director, the Facility Administrator, and/or the Regional Vice President will review the application for discounted care. Approval or disapproval of the application will take place and the patient notified before the case is performed. Written notice including the level of discount allowed will be sent to the patient. Disapproval will include the reason for denial. If the outstanding balance is not paid within the payment terms, the facility has the right to cancel any discount and assign unpaid balances to collections.

- Collection Procedures:
    - Patients are responsible for co-payments, co-insurance, deductibles or the full fee at the time of service as dictated by each state's laws and the constraints of existing contracts, if applicable. The facility staff will collect on or before the day of service any amounts owed for services rendered. All third party payer coverage will be verified in advance of the procedure, and the patient will be contacted to advise them of any payment due. If it is determined the patient cannot pay their amount in full and they do not qualify for an Indigent care or other Discounted Care, the patient will be offered a payment plan or commercial financing. During the registration process, discussions of the patient's financial responsibility will be held with the patient/responsible party. It is essential the financial orientation include a discussion of the deductible and co-insurance requirements. These discussions may include payment plans and/or obtaining patient financing with third party companies. Some examples of payment plans are: (a) 50% at admission and payment of the remaining 50% in thirty (30) days or (b) 50% at admission, 25% in thirty (30) days and 25% in sixty (60) days, or (c) 33% at admission, 33% in thirty (30) days and the final balance in sixty (60) days, or (d) commercially available financing terms. Payment Plan Promissory Notes must be completed and signed by the patient or the responsible party on or before the day of service. The Payment Plan Promissory Notes will state clearly if the patient does not follow the payment plan, the full balance becomes due and payable. Should payment arrangements be made with the patient, after one missed payment the patient should be contacted and given a grace period to make the required payment. Up to a one-month grace period may be granted for delinquent Payment Plan Promissory Notes. If the payment is not made, then the patient will be contacted for immediate payment in full and informed the account will be transferred to a collection agency. Patient balances are to be billed no more than thirty (30) days unless the patient has made arrangements for a Payment Plan Promissory Notes or commercially available financing. Patient statements are processed on a daily basis. Statements are to be sent after any meaningful transaction activity, such as a payment or an adjustment, is posted to an account and the account still has a balance. The patient is to receive a minimum of two (2) statements, one (1) collection letter and a phone call unless payments are made on

schedule. Patient balance collection efforts may be outsourced; however, the vendor will have similar protocols. Patient balances after third-party payer adjudication are to be billed on the regular thirty (30) day schedule unless the contract with the payer prohibits patient-portion billing. The Business Office Manager/Shared Services Center personnel will review accounts forty-five (45) days and older on a weekly basis to ensure these accounts are receiving the proper collection activity. Uncollected patient portion accounts may be placed with a bad-debt collection agency for appropriate collection and follow-up efforts.

- Third party payers (including insurance, government programs, worker's compensation, motor vehicle accident coverage, etc.) will be contacted within forty-five (45) days after original claim submission if payment or other response has not been received. The payer's responses will be documented in the patient's account and a follow-up reminder established for a reasonable amount of time based on what the payer's response is. A reasonable follow up would in no case more than thirty (30) days. The Business Office Manager/Shared Services Center personnel will review accounts on a weekly basis to ensure these accounts are receiving the proper collection activity.

Health-related data, including quality measures and statistics are available electronically at http://www.floridahealthfinder.gov/index.html.