PreOp Diagnosis:	AGE: SEX:
Planned Procedure:	DOS:

Age:	Sex:	Ht:	Wt:	BMI:

MEDICATION RECONCILIATION

☐ **Latex Allergy / Sensitivity**

Allergies:

Additional Allergies/Sensitivities:

Home Medications	Dose/Route	Frequency	Indication	Last Dose	Continue After Surgery
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

MEDICATION GIVEN IN RECOVERY

Discharge Medication	Dosage/Route	Frequency	Indication	Next Dose

PRESCRIPTION(S) GIVEN AT DISCHARGE

PRESCRIPTIONS GIVEN AT DISCHARGE:

☐ Fill the prescription(s) your surgeon has given you and take as directed. Remember to increase fluid intake while on narcotics. Pain medication may upset your stomach, so take medication with food. You may experience drowsiness and dizziness while taking pain medication; therefore, you should not drive, operate machinery, or drink alcoholic beverages while taking narcotics.

☐ Do not take Tylenol with the prescribed narcotic.

☐ If you have been given an antibiotic to decrease the possibility of infection after surgery, take as directed until gone.

☐ **Prescriptions you have been given may interact with medications you currently take. Consult with pharmacist.**

Physician Signature _____ Date _____

Covenant℠ High Plains Surgery Center

Date of Surgery | Physician | Medical Record # | Date of Pre-op Visit

PATIENT INFORMATION

Patient Name (Last, First, Middle) | Social Security Number

Date of Birth | Age | Sex | Race | Marital Status

Mailing Address (City, State and Zip) | Phone Number

Residing Address (if different) | Cell Phone Number

Email Address

Employer

Employer's Address (City, State and Zip) | Employer's Phone Number

Guarantor/Responsible Party | Social Security Number | Relationship

Guarantor/Responsible Party's Mailing Address (City, State and Zip) | Phone Number

Guarantor/Responsible Party's Employer

Guarantor/Responsible Party's Employer's Address (City, State and Zip) | Employer's Phone Number

Person to Contact in an Emergency **(WHO DOES NOT LIVE WITH YOU)**

Address (City, State and Zip) | Phone Number

INSURANCE INFORMATION

Primary Insurance Carrier | Policy Owner's Name | Social Security Number | Date of Birth

Insurance ID Number | Group Number | Group Name

Mailing Address (City, State and Zip)

Secondary Insurance Carrier | Policy Owner's Name | Social Security Number | Date of Birth

Insurance ID Number | Group Number | Group Name

Mailing Address (City, State and Zip)

OTHER INFORMATION

IS THIS A WORK-RELATED INJURY? ☐ ***YES*** ☐ ***NO***

If "YES", please provide the information below.

Date of Injury | Date Reported to Employer | Supervisor's Name

Employer | Employer Address | Telephone Number

Employer's Workers Compensation Insurance Company | File/Claim Number

Pre-Anesthetic Questionnaire

Patient Name: _____

Daytime phone # _____ **Procedure**_____

DRUG & FOOD ALLERGIES: | | None List (explain reaction)**:**

_____ _____

_____ _____

_____ _____

Latex allergy/sensitivity to tape/band-aids? **Circle: Yes No**

Ht _____ **Wt/BMI** _____**(pounds)**_____**(kg)**

Prior surgeries: _____

_____

_____

_____

Tobacco use? Yes No _____packs/day x _____years

Alcohol use? Yes No # drinks per day/week: _____

Caffeine use? Yes No # drinks per day/week: _____

Have pain? Yes No Where: _____1-2-3-4-5-6-7-8-9-10

****ANESTHESIA PROBLEMS for you or any blood relative (i.e., delayed awakening, MALIGNANT HYPERTHERMIA, unexplained fever, difficult intubation, vomiting)? Yes No If yes, explain:**_____

_____

Which of the following do you have or have you had in the past? Please circle Yes or No to each question.

CARDIAC HISTORY

- **Y N Chest pain**
- **Y N Heart attack**
- **Y N Heart failure**
- **Y N Mitral valve prolapse**
- **Y N Rheumatic fever**
- **Y N Heart murmur**
- **Y N Irregular heartbeats**
- **Y N Aneurysms**
- **Y N Heart catheterization or stents**
- **Y N Heart surgery (e.g. bypass)**
- **Y N Pacemaker/Defibrillator**
  Date last checked**:** _____
- **Y N Artificial heart valve**
- **Y N High blood pressure**
- **Y N Cholesterol**

RESPIRATORY HISTORY

- **Y N Asthma**
- **Y N Emphysema or COPD**
- **Y N Chronic cough**
- **Y N Shortness of breath**
- **Y N Sleep APNEA and/or CPAP**

OTHER MEDICAL HISTORY

- **Y N Blood Clots in legs or lungs**
- **Y N Tuberculosis**
- **Y N Diabetes:**
  If yes, circle below:
  Insulin Pills Diet
- **Y N Hypoglycemia**
- **Y N Kidney disease**
  If yes, do you have a dialysis shunt or on dialysis? _____

_____

- **Y N Ulcers**
- **Y N Weight loss**
- **Y N Thyroid disease**
- **Y N Liver disease**
- **Y N Hepatitis**
  Circle type if yes: A B C
- **Y N Lupus**
- **Y N Anemia**
- **Y N Bruise or bleed easily**
- **Y N Sickle cell disease**
- **Y N Strokes**
  Y N weakness?
- **Y N TIA (mini-stroke)**
- **Y N Parkinson's disease**
- **Y N Seizures or epilepsy**
  Date of last seizure:

  _____
- **Y N Migraines**
- **Y N Memory loss**
  If yes, do you sign your papers? Y N
- **Y N Psychiatric disorders**
- **Y N Depression**
- **Y N Glaucoma**
- **Y N Artificial joints**
- **Y N Artificial limbs**
- **Y N Amputee**
- **Y N Back pain**
- **Y N Neck pain**
- **Y N Herniated discs**
- **Y N Cancer**
  Type: _____
  Chemotherapy
  Radiation therapy

Birth defects: _____

_____

DO YOU:

- **Y N Have anything contagious** (fever, cough rash, open sores)
- **Y N Have MRSA, AIDS or HIV**
- **Y N Have night sweats**
- **Y N Use recreational drugs**
- **Y N Get preventative antibiotics before procedures**
- **Y N Have you had any recent respiratory infections, other type of infections or hospitalization**
  Describe and list date(s) _____

  _____
- **Y N Wear Oxygen**
  Type: _____
- **Y N Wear contact lenses**
- **Y N Wear glasses**
- **Y N Wear hearing aids**
- **Y N Have body piercing** (besides ears) If yes, where?

  _____
- **Y N Have dentures, partials, loose teeth or periodontal disease**
- **Y N Use cane, walker or wheelchair**
- **Y N Are you prone to falling**
- **Y N Have an ostomy**

  _____
- **Y N Need a translator day of surgery**
  If yes, what language:

  _____

- **Y N Take blood thinners or anti-Inflammatories**
  (Plavix, Coumadin, Pradaxa, Effient, Aspirin, Motrin, Advil, Aleve, Mobic, Naprosyn, Celebrex, Aggrenox, etc.)

Did you stop this medication? Y N
Date last taken: _____

WOMEN ONLY:

- **Y N Are you pregnant now**
- **Y N Are you breastfeeding now**
- **Y N Take hormones or Tamoxifen**
- **Y N Ever had a tubal or hysterectomy**
  Last menstrual cycle
  Date_____

_____ _____

Nurse Signature **Date**

Please list the name(s) of your current physician(s) (i.e. primary care physician, cardiologist, pediatrician, orthopedist)**:**

Physician name	**Specialty**	**Date of visit**

Emergency contact (name/phone number): _____ **Responsible Adult:** _____

I certify that my health history was reviewed and updated by me on: (sign once per date of service)

_____

Today's Date	**Patient Signature**	**Witness**
Today's Date	**Patient Signature**	**Witness**
Today's Date	**Patient Signature**	**Witness**

ADMISSION AGREEMENT

Consent for Admissions: I request and consent to admission to Covenant High Plains Surgery Center (C*HPSC*).

Consent to Medical Care: I request and consent to medical care and diagnostic procedures that my attending physician(s) or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in C*HPSC* is under the direction of my attending physicians(s) and that the Center is not responsible for acts of omission of my attending physician(s). There are certain types of operations and procedures, such as direct abortion, which are not authorized at the surgery center located on Quaker Avenue and I agree to such policy as condition of admission.

Release of Information: I authorize C*HPSC* to release any medical or financial information to a medical care provider who is performing medical care or a diagnostic test(s) on behalf of; or at the request of my attending physician, or his/her designees, of the Center. I authorize C*HPSC*, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. **By state law,** you must be advised that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which includes, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Legal Guardian, Medical Durable Power of Attorney, Advance Directives:

Do you have a Legal Guardian? ☐ Yes ☐ No
If yes, please provide Name_____
Do you have a Medical Durable Power of Attorney? ☐ Yes ☐ No ☐ Copy on Chart
If yes, please provide Name_____
Do you have an Advance Directives? ☐ Yes ☐ No ☐ Copy on Chart

Privacy Practices, Patient Rights, Physician Ownership, Advance Directives and Patient Financial Responsibility Policies:

Have you received a copy of the CHPSC Notice of Privacy Practices? ☐ Yes ☐ No
Have you received a copy of the CHPSC Patient Rights and Responsibilities? ☐ Yes ☐ No
Have you received a copy of the CHPSC Physician Ownership Statement? ☐ Yes ☐ No
Have you received a copy of the CHPSC Advance Directives Policy? ☐ Yes ☐ No
Have you received a copy of the CHPSC Patient Financial Responsibility Policy? ☐ Yes ☐No

Personal Property: I have been informed and understand C*HPSC* does not assume any responsibility for personal property that I choose to keep with me. I have been informed; however, that C*HPSC* does have a safe in which I can deposit personal property for safekeeping. I have been informed and understand that C*HPSC* will not be liable for any loss of my personal property unless it is placed in the safe maintained by C*HPSC*.

Payment for Medical Care: I agree that, in consideration for the medical care I receive from the Center, its employees, agents, designees, or independent contractors, I guarantee full payment for all changes by C*HPSC* or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party payor (for example, an insurance carrier or health maintenance organization (HMO) with which Center has specifically entered into an agreement for payment of medical care provided by the Center or by its employees, agents, designees or independent contractors). In the event that C*HPSC* has to engage an attorney or collection agency to collect any unpaid balances that arise form the treatment consented to and services provided herein, I agree to pay the reasonable attorney's fees and collection expenses, including, without limitation, collection agency expenses, incurred by C*HPSC*.

Assignment of Benefits: I hereby authorize and assign payment to C*HPSC*, any type of reimbursement or payment from Medicare or State Medicaid programs or other third party payor, for any and all cost of my medical care provided at the Center or by its agents, designees, or independent medical contractors. Further, I understand that **Anesthesiology, Physician Services, Pathology, Radiology** and some **Laboratory Services** may be billed to me separately and I assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim

Insurance Precertification: I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Release of Financial Information: I herby authorize C*HPSC*, its employees, agents, designees, or independent contractor to disclose any and all information regarding the medical care I received on the admission to this facility or through its employees, agents, and designees, or independent contractors to any third party payor responsible for paying the costs of my medical care and any part thereof.

Agreement as to Governing Law and Forum: The patient or patient's representative and health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall by governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

I have reviewed this Admission Agreement and fully understand its contents and implications.

_____
Signature of Patient, Parent, or Legal Guardian Date Please Print Name of Patient, Parent, Guardian

_____
Signature of Guarantor Relationship to Patient Date Please Print Name of Guarantor

_____ CHPSC
Employee Signature Date Please Print Name of CHPSC Employee

If Legal Guardian or Other Legal Representative for the Patient, please provide your age and relationship to the patient, and the reason why the Patient is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or are a parent or legal guardian of a child.

Covenant High Plains Surgery Center

Patient Label

IMPORTANT INFORMATION REGARDING THE BILLING

OF YOUR ANESTHESIA SERVICES

The services of your anesthesia care team is provided by North Star Anesthesia Group (NSA) and services are a separately billable from the Covenant High Plains Surgery Center facility fee(s), laborartoy charges or the surgeon's charges(s). As a convenience, NSA has agreed to file a claim with your insurance company for your anesthesia services. Due to individual coverage variables with each patient's insurance benefits, NSA may not be able to accurately determine what percentage the insurance carrier will pay for anesthesia services; therefore it is the patient's responsibility to contact you insurance company for compete benefit information.

North Star Anesthesia Group (NSA) will collect payment for the anesthesia service from the insurance carrier. If there is any remaining balance, NSA will mail the patient a statement. It is the responsibility of the patient to make their payment in full or contact NSA to make payment arrangements.

If you do not have insurance, payment in full is required on or before the day of surgery, unless prior arrangements are made with NSA.

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

AND CONTRACT FOR PAYMENT

In consideration of services rendered, I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to North Star Anesthesia Group (NSA). This assignment will remain in effect until revoked by me in writing. I hereby authorize NSA to release all information that may be necessary to secure payment for their charges.

I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. Upon receipt of a statement from NSA, I agree to pay the remaining balance in full or contact their office to discuss payment arrangements.

_____ _____

Patient Name Witness

_____ _____

Signature (Parent or Legal Guardian if patient is a minor) Date

Please call NSA if you have any questions regarding charges for anesthesia services. Thank you for using Covenant High Plains Surgery Center.

North Star Anesthesia Group

1161 Corporate Drive West, Suite 150

Arlington, TX 76006

(800) 963-3271

or 833-988-4677

Covenant High Plains Surgery Center

2301 QUAKER AVE, LUBBOCK TX 79410

ADMISSION CONSENT

Additional Blood Testing:

I understand that my physician may order a blood test drawn from me for (including but not limited to) HIV (AIDS) and Hepatitis antibodies. I understand that I can obtain the results of these tests from my physician who can explain them.

_____ I consent to that withdrawal *only* if an employee or physician has had an accidental exposure to my body fluids. I authorize release of data necessary to process the testing and the insurance claim and I understand there will be no cost to me for this test.

Photographs/Video Tapes:

I understand these photographs and/or video tapes are the property of my surgeon.

_____ I consent for any photographing or video taping deemed necessary by my surgeon for medical scientific or educational purposes provided my identity is not revealed.

I certify that this form has been fully explained to me, that I have read it or have it read to me, and that I understand its contents.

Signature of Patient, Parent, or Legal Guardian Date PRINT Name of Patient, Parent, or Guardian

Relationship if signed by person other than Patient _____

WITNESS/INTERPRETER: _____

PATIENT LABEL

Permission for Disclosure to Family, Friends, and/or Caregivers

To Patient:

I understand patient health information is protected and confidential. With this understanding, I hereby grant the **Covenant High Plains Surgery Center** staff permission to discuss my health related matters with family, friends, caregivers or other designated persons, listed below.

Relevant health information may be shared with the following family members, other relatives, close personal friends, or other persons identified. Please mark applicable line and insert name of person or persons applicable.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Disclosure UPDATED by patient:

Date and initial of patient: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Name: _____ **Date:** _____

Patient Signature: _____

Covenant High Plains Surgery Center

Patient Label

PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not A Revocation Of Advance Directives Or Medical Powers Of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Center respects and upholds those rights.

However, unlike in an Acute Care Hospital setting, the Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

Therefore, as a matter of conscience, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an Acute Care Hospital for further evaluation. At the Acute Care Hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

PLEASE CHECK THE APPROPRIATE BOX IN ANSWER TO THESE QUESTIONS.

HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, OR A POWER OF ATTORNEY THAT AUTHORIZES SOMEONE TO MAKE HEALTH CARE DECISIONS FOR YOU?

- ❑ YES, I HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.
- ❑ NO, I DO NOT HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.
- ❑ I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES.

If you checked the first box "yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described.

By: _____
(Patient's Signature)

Patient's Last Name:	Patient's First Name:	Date:

If consent to the procedure is provided by anyone other than the patient, this form must be signed by the person providing the consent or authorization.

I acknowledge that I have read and understand its contents and agree to the policy as described.

By: _____
(Signature)

_____
(Print Name)

Relationship to Patient

☐ Court Appointed Guardian ☐ Attorney in Fact ☐ Health Care Surrogate ☐ Other

Covenant High Plains Surgery Center

Covenant High Plains Surgery Center complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

PATIENT RIGHTS AND RESPONSIBILITIES

The facility and medical staff of Covenant High Plains Surgery Center have adopted the following list of patient rights and responsibilities. This list shall include, but not limited to:

PATIENT RIGHTS

The patient has the right:

- To exercise his or her rights without being subjected to discrimination or reprisal.
- To be free from all forms of abuse or harassment.
- To know of the name and professional status of those caring for him or her.
- To receive information from the physician about his or her diagnosis, treatment plan and prognosis to the best of the physician's knowledge.
- To participate actively in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Of full consideration of privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely.
- To be informed that advanced directives cannot be honored in this facility and to be advised that should an unexpected, life threatening event occur, the patient will be transferred to a facility that will honor their directive.
- To receive responsible responses to any reasonable requests for service.
- To leave the facility even against medical advice.
- To expect reasonable continuity of care.
- To be advised if the physician proposes to engage or perform experimentation affecting your care of treatment and the right to refuse to participate in the activity.
- To be informed of the continuing health care requirements following discharge from the center.
- To examine and receive an explanation of a bill or service, regardless of source of payment.
- To report any comments concerning the quality of care provided to you and expect follow-up on your comments.
- To be informed of their right to change providers if other qualified providers are available.

PATIENT RESPONSIBILITIES

The Patient is responsible:

- For providing accurate and complete information concerning his present complaints, past medical history and other matters relating to their health.
- For notification of the existence of an advanced directive (as a living will) as those cannot be honored in this facility.
- For making it known whether they clearly comprehend the course of their treatment and what is expected of them.
- For following the treatment plan established by the physician, including the instructions of nurses and other health care professionals as they carry out the physician's orders.
- For keeping their appointment and notifying the facility if they are unable to do so.
- For providing a responsible adult to drive them home and stay with them for 24 hours after surgery.
- For providing complete and accurate insurance information (if applicable) and assuring that the financial obligations of their care are fulfilled as promptly as possible.
- For being considerate of the rights of other patients and facility personnel.

FEEDBACK

Our goal is to provide the best surgical experience possible while in our center. Patients, clients, families or visitors have the right to express complaints or concerns about any aspect of their care or experience with Covenant High Plains Surgery Center. Please be assured that expressing a complaint or concern will not compromise your care.

Concerns may be directed to any CHPSC staff member, the Director of Nurses or the Director of Business Services.

You may also mail your comments to:

Covenant High Plains Surgery Center Administrator
3610 22nd Street
Lubbock, TX 79410

If this venue does not provide you with an acceptable resolution, any complaints may be submitted to:

Health Facility Compliance Division/MC 1979
Texas Department of Health
1100 West 4th Street, Austin, TX 78756
Fax: (512) 834 6653 • Telephone: (888) 973-0022

For more information, please visit the Office of the Medicare Beneficiary Ombudsman via the internet at: www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html or by calling 1 (800) MEDICARE.

Covenant High Plains Surgery Center

PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care. We encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, Visa, MasterCard, Discover, American Express and CareCredit.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier.** If your insurance requires referrals/pre-authorization for full benefits to be paid, it is your responsibility to verify that the referrals/pre-authorizations are in place prior to your visit.

3. **The facility charge at the surgery center is a flat fee for use.** All supplies are included in this charge except for billable prosthesis, implants, pharmaceuticals, or transplant tissue which are billed as separate charges.

4. **Our facility will file both primary and secondary insurance claims for medical services rendered.** Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

5. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.

6. **You will receive a statement from our office within 45 days of your insurance company's response.** If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement.

7. **We are participating providers for Medicare.**. This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20% plus any out-of-pocket deductibles. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient by federal law, must be held responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

8. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved, without including our facility.

9. **All accounts that are 60 days or more past due, may be turned over to a collection agency** and High Plains Surgery Center may cease providing services to you.

10. **In the unlikely event your payment is returned unpaid,** we may elect to re-present your payment either electronically (or by paper draft) to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed that permitted by state law.

It is our hope that you will find this information helpful. If you have questions, please speak with our billing staff at (806) 776 4813 or (806) 776 4814.

Covenant High Plains Surgery Center

PHYSICIAN OWNERSHIP STATEMENT

The physicians listed below are limited partners in Covenant High Plains Surgery Center, L.L.C. An interest in this facility enables them to have a voice in the administration and medical policies of this health care institution. This involvement helps ensure the finest quality of care for their patients. Covenant High Plains Surgery Center, L.L.C. places special emphasis on fully informing our patients of this ownership. It is our goal to inform you and treat you professionally at all times.

Rebeccah Baucom, M.D.
Charles Bayouth, M.D.
James Boop, M.D.
Hemmo Bosscher, M.D.
Job Buschman, M.D.
Joel Campbell, M.D.
Courtney Cowden, M.D.
Kevin Crawford, M.D.
David Cuthbertson, M.D.
Mark D'Alise, M.D.
Sammy Deeb, M.D.
Janelle Dorsett, M.D.
Travis Eggl, M.D.
William Fell, M.D.
Robert Gaines, M.D.
Melinda Garcia-Schalow, M.D.
Danny Hunter, M.D.
Joseph Killeen, M.D.
Robert King, M.D.
David Mangold, M.D.
Jonathan Mannas, M.D.
Melinda Nickels, M.D.
Brian Norkiewicz, M.D.
Michel Oliva, M.D.
Jennifer Owen, M.D.
Michael Owen, M.D.
Ryan Owen, M.D.
Karl Pankratz, M.D.
Kim Pershall, M.D.
Stanley Potocki, M.D.
Adam Purtell, M.D.
Sammy Rivas, M.D.
Catherine Ronaghan, M.D.
Richard Rosen, M.D.
Jane Rowley, M.D.
Fatima Salas, M.D.
Caleb Sallee, M.D.
Philip Scolaro, M.D.
David Shephard, M.D.
Zuhair M. Shihab, M.D.
Harold Smith, M.D.
John Streit, M.D.
Elbert Thames, M.D.
Stan Thornton, M.D.