PHYSICIANS
Surgical Center

1840 Quentin Road • Lebanon, Pennsylvania 17042
Telephone (717) 272-0007 • FAX (717) 675-2247

INSURANCE LIABILITY WAIVER

Patient Name: _____

Thank you for choosing the Physicians Surgical Center as your surgical facility. Our staff welcomes you to an environment where we seek to "exceed" your expectations. You will find a facility with state of the art medical equipment, supporting quality care. Professionals known for efficiency and compassion will welcome you into your experience, focusing on patient comfort and convenience, with positive outcomes. From registration to discharge, we want you to feel comfortable and valued. We appreciate this opportunity to serve you.

Because of the rise in health care costs, we take a moment to inform all patients of their charges prior to surgery. We want everyone to be aware of the liabilities associated with each procedure. This form serves as a liability form. Please feel free to ask any questions before signing.

By signing this form, you the patient/parent/guardian understand that the insurance may or may not cover certain procedures performed at the surgery center. In the event that your insurance company determines that a procedure is non-covered or not medically necessary, you realize that you will be responsible for the amount not covered by your insurance plan.

In the event that a procedure is scheduled at the center and your insurance is not in effect at the time services are rendered, you understand that by signing your name below that you are responsible for the amount billed by the Physicians Surgical Center.

In the event that your insurance does not cover all charges because they do not recognize us as an in-network provider, you understand that you will be responsible for all charges/fees not covered, at an in-network rate.

Remember: ALL FEES BILLED BY ANESTHESIA, PATHOLOGY AND THE SURGEON ARE BILLED SEPARATELY.

”My signature represents my understanding of this Insurance Liability Waiver. I will receive a copy of this waiver for my records at my request.”

Patient Signature: _____

Witness: _____ **Date:** _____