Consent to Medical and Surgical Procedures: The undersigned consents to the procedures which may be performed during this outpatient basis, including emergency treatment or services, which may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or facility services rendered to the patient under the general and special instructions of the patient's physician or surgeon. I understand that nursing and other health care personnel may be among the individuals who will provide care to me.

Legal Relationship between Facility and Physician/s: All physicians and surgeons (not listed in the Partnership Notification) furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors with the patient and are not employees or agents of the facility. I have been made aware of and reviewed the Partnership Disclosure. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the facility and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, for the medical or surgical treatment, special diagnostic or therapeutic procedures, or facility services rendered to the patient under the general and special instructions of the physician.

Personal Valuables: The facility shall not be liable for loss or damage to any other personal property, unless deposited with the facility for safekeeping, which is limited by statute to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the facility by the patient.

Financial/Insurance Agreement:

- The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the facility in accordance with the regular rates and terms of the facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

- The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the facility of any insurance benefits otherwise payable to or on behalf of the patient for these outpatient services, including emergency services if rendered, at a rate not to exceed the facility's actual charges. It is agreed that payment to the facility, pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this assignment.

- Healthcare Service Plan Obligation: This facility maintains a list of healthcare service plans with which it contracts. A list of such plans is described in the Notice to Patient. The facility has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is

individually obligated to pay the full charges of all services rendered to him/her by the facility if he/she belongs to a plan which does not appear on the above mentioned list.

Acknowledgement of Receipt of Patient Information Booklet:

- The Notice of Privacy; Patient Rights and Responsibilities; Complaint Process; Visitation Policy has been received and reviewed.

Privacy Notice: I understand that my name, location, and general condition will be listed in the patient directory, and that this information will be accessible to people who ask for me by name, such as relatives and friends, and to clergy. The directory may also include my religious affiliation, which may also be disclosed to clergy. Upon request, we can review any of these policies in more detail.

ADVANCE DIRECTIVE: I understand Southpoint Surgery Center provides "elective" surgery, and will not honor an Advance Directive/Living Will if an unexpected complication were to arise during treatment at the surgery center. I understand that Southpoint Surgery Center will honor my right to formulate, review, revise, or revoke a living will. A copy of the Advance Directive must be in the medical record to be honored.

The undersigned certifies that he/she has read the foregoing, and received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.