SOUTHEASTERN SURGERY CENTER

2000 Centre Pointe Boulevard – Tallahassee, FL 32308
Voice: 850-878-9992 – Fax: 850-878-9637

Part 1 **ESTIMATE OF FEES – DESCRIPTION OF SERVICES – DISCLOSURE OF OWNERSHIP**

CPT CODE(s): Description

_____ _____

Insurance Co. (s) _____ Total Estimate: _____

Insurance Coverage: _____ **Patient Responsibility**: _____

NOTE: The above fees are ***estimates*** based on the procedures scheduled by your provider and include facility charges only: If your surgeon performs different or additional procedures, these fees will change. The surgeon's fee and anesthesiologist's fee are each billed separately. If lab or pathology is needed, you will receive a separate bill from these other companies. In addition, the insurance coverage and patient responsibility stated above are on any estimate based on information received from your insurance carrier. For further, specific details on your itemized coverage and cost-sharing responsibilities, contact your insurance carrier. A phone number can be obtained via your insurance card as well as our website links to carriers for which we participate on our website. Please note that fees may be less for procedures and services at other healthcare facilities and your actual costs may vary from estimate.

Additional providers billed separately from Southeastern Surgery Center:

Pathology:

(1) Advance Urology Pathology – (727) 441-1509
26750 US Highway 19 N Suite 200 | Clearwater, FL 33761

(2) Ketchum, Wood & Burgert Pathology Associates (850) 878-5143
1899 Eider Court | Tallahassee, FL 32308

Lab:

(1) Advance Urology Lab – (727) 441-1509
26750 US Highway 19 N Suite 200 | Clearwater, FL 33761

(2) Lab Corp – (866) 697-8378
2477 Tim Gamble Place #102 | Tallahassee, FL 32308

(3) Quest Diagnostics – (866) 697-8378
1605 E Plaza Drive | Tallahassee, FL 32308

Anesthesia:

(1) Anesthesiology Associates of Tallahassee – (850) 385-0144
2173 Centerville Place, Ste. A | Tallahassee, FL 32303

Physician Services:

(1) Advance Urology Institute – (727) 441-1509
26750 US Highway 19 N Suite 200 | Clearwater, FL 33761

(2) Southern Vitreoretinal Associates – (850) 942-6700
2349 Care Drive | Tallahassee, FL 32308

Please be advised to the following own at interest in Southeastern Urological Partner, Ltd. Dba/Southeastern Surgery Center:

Robert S. Bradford, MD	David E. Burday, MD	Charles K. Newell, MD	Jean-Paul Train, MD
H. Logan Brooks, MD	James E. Renehan, MD	Robert L. Steinmetz, MD	Jamey A. Sarvis, MD

You have been referred to Southeastern Surgery Center to obtain the items or services listed; however, you are entitled to choose another location of care as an alternative source for the items or services including:

(1) HCA Florida Capital Hospital – (850) 325-5000
Capital Medical Blvd. | Tallahassee, FL 32308

(2) Tallahassee Memorial Hospital – (850) 431-1155
Magnolia and Miccosukee | Tallahassee, FL 32308

Part II **PAYMENT AGREEMENT**

I requested health care services from Southeastern Surgery Center (**"Surgery Center"**). I understand the Surgery Center may or may not have a provider contract with my health plan for which it will file for benefits covered by the insurance company. I understand that I am responsible for my co-pay and/or deductible for which I am obligated under my health plan provisions (patient obligations).

I agree to pay the Surgery Center the full amount of the patient obligation to the extent not paid before the procedure, or otherwise agreed in a attached plan effective only if signed by both parties. I understand that If I do not fulfill my obligation at agreed, any remaining balance will be due in full immediately. A $50.00 return check charge will be added to the outstanding balance.

Part III **PAYMENT AND FINANCIAL POLICY**

Attached is a copy of our Payment and Financial Assistance Policy with notification of payment plan options and collections procedures. Upon discharge you are entitled to request a copy of your itemized statement and shall receive such within 7 days of receipt of request.

ACKNOWLEDGEMENT BY PATIENT OR LEGAL REPRESENTATIVE

I acknowledge disclosure of fees and ownership to be by Southeastern Surgery Center of the information set forth as above. I understand that the *estimate of fees* is an *estimate* only. In addition, I will comply with the payment terms outlined in the payment agreement above.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name

_____ _____
Witness Signature Date

Form 809
Revised 4/30/2024