



n e w p o r t
Center for Special Surgery

1401 Avocado Avenue, Suite 101
Newport Beach, CA 92660

Phone 949 644-8182
Fax 949 759-5566

Patient Responsibilities

I shall follow the treatment plan prescribed by my provider and participate in my care.

I shall provide a responsible adult to transport me home from the facility and remain with me for 24 hours, if required by my treating physician. The responsible adult will be available immediately on discharge from the facility.

I shall accept personal financial responsibility for any charges not covered by my insurance.

I shall be respectful of all the health care professionals and staff, as well as other patients.

Policy regarding cancellation of Surgery:

I shall be liable for the full Facility fee, full Anesthesiologist fee, and any special equipment charges if cancellation of a scheduled surgery is made within 48 hours of the scheduled surgery time.

A: Exception of this policy will apply if the patient reports for the surgery and is deemed unfit by a Physician to proceed with the surgery.

I have read and understand the above notice.

Patient's signature

Date