DISCLOSURE OF FINANCIAL INTEREST

You (or your legal representative on your behalf) acknowledge that your physician may participate in one or more quality and efficiency programs operated by your health insurer. These programs provide a financial incentive to participating physicians to achieve certain quality targets and to select cost effective, participating facilities for your care. The facility to which you have been referred is one such participating facility:

Name of Facility: Surgical Center of the Rockies

Address of Facility: 2446 Research Parkway, Ste. 100; Colorado Springs, CO 80920

The incentive payment, which is paid by your health insurer, is in addition to the physician's normal professional fee. If your physician participates in such a quality and efficiency program and that program is applicable to your care at this facility, alternative referrals will be made by your physician upon your request—you have the right to obtain the referred services or items at the facility of your choice, unless otherwise restricted by law. If no request is made, you acknowledge herein that you consent to your physician's choice of facility.

You also acknowledge receipt, on the date indicated below and at the time of this referral, of a copy of this Disclosure of Financial Interest.

You further acknowledge that your physician may own an interest in this facility and/or otherwise may have a financial interest in this facility.

Further information may be obtained from the business office of the facility.

By signing below, I acknowledge that, on the date indicated below, I have read and understand the disclosures set forth above.

PATIENT OR LEGAL REPRESENTATIVE OF PATIENT:

Signature of Patient or Legal Representative: ______________________________

Printed Name of Patient: ______________________________

Date: ______________

PATIENT LABEL

Classified as Confidential