SURGICAL ASSOCIATES, P.C.
BILLING & PAYMENT POLICY

As validated by my signature on the bottom of this form, I understand that:

1. Surgical Associates is committed to providing the best possible treatment for our patients at rates that are customary and usual for our area. I understand that I am responsible for any charges not fully covered by my insurance company regardless of their interpretation of what is "usual and customary."

2. I will receive a monthly statement that will detail all charges, payments, and credits entered on my account during the month preceding the closing date of the statement. Monthly payments are required every thirty (30) days.

3. Non-insured patients will be expected to pay at the time of service, or make arrangements with the Office Manager.

4. Office co-pays are required at the time of service. We grant sixty (60) days for the insurance to pay; however, any balances pending insurance or non-covered by insurance are the obligation of the responsible party.

5. Surgical Associates accepts assignment on BC/BS, Medicaid, Medicare, and certain PPO's, and we will submit the claims for you. Claim forms for all other insurances will be submitted directly to your insurance company if we have the correct information. Otherwise, it will be your responsibility to send claims to both your primary and (if applicable) your secondary insurance carrier.

6. You are responsible to pay all charges denied or excluded by your insurance company.

7. A compound finance charge equal to the maximum allowed by federal regulations will be levied against the unpaid balance of accounts that are sixty (60) days old or older if regular payments are not being made.

8. I understand that I will not be billed or held responsible for any charges if approved as a work related incident.

9. A copy of this policy will be retained by me.

I am covered by health insurance: (yes) (no) - circle one.

Name of primary insurance carrier:_____ ( ) Medicare ( ) Medicaid

Account number (to be supplied by office) _____

Patient name:_____ Date:_____

Signature of responsible party: _____