ERIC R. DRINGMAN, M.D., F.A.C.S.
KATHRYN F. HATCH, M.D., F.A.C.S.
BARRY A. McKENZIE, M.D., F.A.C.S.
RACHEL L. OTT, M.D., F.A.C.S.

SURGICAL ASSOCIATES PC
2900 12th Ave North, Suite 355W, Billings, MT 59101
(P) 406-238-6470 / (F) 406-238-6499
www.billingssurgeons.org

GEORGE K. BENTZEL, M.D., F.A.C.S.
JEFFREY J. RENTZ, M.D., F.A.C.S.
MICHAEL G. WILCOX, M.D., F.A.C.S.
JUSTIN C. BREWER, M.D.

BILLING & PAYMENT POLICY

As validated by my signature on the bottom of this form, I understand and agree to the following:

1. Surgical Associates, PC is committed to providing the best possible treatment for our patients at rates that are usual and customary for our area. The patient/responsible party is responsible for any charges not fully covered by insurance regardless of their interpretation of what is "usual and customary."
2. Non-insured patients will be expected to pay a minimum of $100 at the time of service or can request other payment arrangements with the Billing Office.
3. Surgical Associates, PC accepts most types of insurance and will submit claims directly to the insurance company on behalf of the patient. If applicable, insurance co-pays are required at the time of service. If we do not receive the correct information to submit the claim(s), the patient/responsible party will receive a statement and is responsible for payment.
4. It is the responsibility of the insured to verify coverage, benefits, deductibles, etc. prior to receiving care in our office. The patient/responsible party will be responsible to pay for all charges denied or excluded by the insurance company.
5. Surgeries are often performed by a primary surgeon AND an assistant surgeon/physician assistant. Therefore, statements could reflect charges for both on the same date(s) of surgery.
6. Patient/responsible party will receive a monthly statement that will detail all charges, payments, and other activity received on the account during the month preceding the closing date of the statement. Payment in full is expected 30 days from date on statement, or an agreed upon minimum payment is required every 30 days to keep the account in good standing.
7. Accounts not in good standing will be reviewed on a regular basis and sent to an outside collection agency when no payment is received or if a payment plan is not in place.
8. A compound finance charge equal to the maximum allowed by federal regulations will be levied against the unpaid balance of accounts that are 60 days old or older if regular payments are not being made.
9. Patient/responsible party will not be billed or held responsible for charges if treatment received is for a pre-approved work-related accident.
10. Patient/responsible party can request a copy of this policy once signed. A copy will also be placed in the medical record of the patient.

Is patient covered by insurance (circle one): YES NO
If YES, name of insurance(s) to submit claim(s) to: *copies of insurance card(s) will be obtained by office staff*
Primary Insurance: _____
Name/DOB of Subscriber if other than patient:_____
Secondary Insurance: _____
Name/DOB of Subscriber if other than patient:_____
Tertiary Insurance: _____
Name/DOB of Subscriber if other than patient:_____

PRINTED Patient Name: _____ **DOB:** _____

Patient/Responsible Party SIGNATURE: _____**Date:** _____

If this form is NOT signed by the patient complete the following:
Printed Name: _____Relationship to Patient: _____