

# General Surgery

## Financial Policy Agreement

Please read and sign the following policy to avoid any misunderstandings. If you have any questions, please ask for clarification.

1. We require a current copy of your insurance card at check-in; otherwise payment will be expected at time of service.
2. All co-pays are due at time of service. If you do not have your co-pay you will need to reschedule your appointment. We accept Cash, Visa, MasterCard, Discover and personal checks.
3. As a courtesy to you we file most primary insurances. In order to do this we will need all your current and correct insurance and demographic information prior to submitting your claim.
4. Please see our list of participating insurance companies. If you have insurance that is not on our list you may still have "out of network" benefits. Call your insurance company and ask what your options would be for "out of network". Give the doctor's name; he may be listed under a contracted pricing company.
5. Please realize that if your insurance company deems a service to be "non-covered" you are responsible for payment.
6. Medicare will only pay for services that are deemed "reasonable and medically necessary", therefore you will be asked to sign a waiver if we determine that your services would likely be denied, and you would be responsible for those charges.
7. If you have an insurance policy that requires referrals for specialist office visits, please have your referring physician fax it to our office prior to the appointment date; it is ultimately your responsibility to make sure the authorization has arrived before your appointment or you may be asked to reschedule, or be billed for the services.
8. All balances are due and payable within 90 days of the service date or your account will be sent to a collection agency; this will allow sufficient time for insurance to process and for you to respond to billing statements.
9. We do not bill for accidents involving litigation. You will be required to pay at time of service.
10. All workmen's compensation information is required at check-in for any work related injuries. The required information is available upon request.
11. Self pay patients are asked to pay 50% of any surgery estimates prior to surgery.
12. If you have applied for Medicaid, but have not received a card or proof of current coverage you will be considered a self pay and payment is expected at the time services are provided. A current card is required for each visit, regardless of when you were here last.
13. All Medical-form completion will obtain a charge of \$10 per form request. If additional information is needed, that cannot already be found in the chart in order to complete the requested form, a scheduled visit may also be required. Once all pertinent information is received, the form will be completed with 7-14 days of submitted payment.
14. Responsibility for any services to minor children rests with the parent seeking treatment unless a court ordered judgment is in place. A parent or legal guardian must accompany minors under the age of 18 for all appointments.
15. Before the scheduling of any surgery, please check your dates, we charge \$20 if you reschedule your surgery.
16. Please be aware that services you receive in the office or hospital may involve other medical parties, therefore you may have additional charges such as lab, pathology, anesthesia, etc.
17. Any return check by the bank for "NSF" or "Closed Account" will be charged a \$25 service fee in addition to the amount of the returned check. We reserve the right to not accept personal checks from you if your account has a return check fee charge.
18. Patients are seen by appointment time, not arrival time.

### Authorization:

I agree to be responsible for my medical expenses regardless of insurance coverage. I authorize my insurance company, attorney or other parties to provide any payment information regarding my bill and make payment directly to Bariatric Specialists of NC, PA. I agree to pay all costs incurred if my account should become delinquent, including reasonable attorneys fees. I have read, understood and agree to this financial policy and I accept full responsibility for any balance due.

I authorize the physician in charge to administer medical care as is necessary, and allow release of medical records and x-rays to any party involved in my treatment.

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Signature of patient or legal guardian

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Date