SURGICAL CARE SPECIALISTS, Inc.

PATIENT _____

Thank you for choosing Surgical Care Specialists (SCS) as your surgical provider. We are committed to providing you with the best available care. We ask that all responsible parties read and sign our financial policy. If you have any questions please feel free to ask our staff to discuss any fees or this policy with you.

As the responsible party, please understand:

1. SCS will bill your insurance company on your behalf; however, you are ultimately responsible for the bill.
2. You are financially responsible for any balance not covered by your insurance carrier.
3. Co-payments, co-insurances and deductibles are due at the time of your visit.
4. You are required to pay your portion of any surgery/procedure prior to the procedure date. SCS will provide you with an estimate of your financial responsibility when possible and a date which payment is due.
5. Please inform the receptionist of any changes in your address or insurance coverage.
6. You are responsible for providing a referral from your primary care physician should the insurance require one. If your insurance company denies payment due to non referral, you, the patient, agree to pay SCS in full for any charges incurred during the visit.
7. If you fail to make any payment which you are responsible for, your account may be turned over to a collection agency. You will be responsible for payment of reasonable collection and legal fees.
8. In the event that a check is returned, you are responsible for the amount of the check plus any bank charges. SCS will not charge any additional fees.
9. The completion of disability and/or FMLA forms are not billable/reimbursable by insurance companies, therefore charges are your responsibility. SCS fees related to completion of these forms is $10.00 per form.

SCS understands that financial problems may affect timely payments, so we encourage you to communicate any such problems to us, so that we may assist you.

Surgical Care Specialists is authorized to release to my insurance company(s) any necessary information needed to file and expedite payment of my claims. Assignment of any benefits should be payable on my behalf to Surgical Care Specialists.

Print Name _____ D.O. B _____

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Signature or legal representative Date