

FINANCIAL AGREEMENT

Welcome to Surgical Associates. To better understand your financial responsibility, we ask that you read and sign the following:

As a courtesy, we will submit your bill to your insurance company. Please be sure to bring your insurance identification card with you at the time of your office visit.

If you are not a member of an HMO or Medicare, we request that you pay twenty-five percent (25%) of your bill for office visits at the time of service. In anticipation of payment from your insurance company, we will set aside the remaining balance for thirty (30) days. If your insurance company does not remit payment within this period, you will be responsible for the balance. If you are a member of an HMO, please be sure to bring your referral form and your co-payment with you at the time of your office visit.

Where necessary, we will do our best to work out financial arrangements satisfactory to both the patient and this medical practice. Once an arrangement is made, the patient/guarantor is expected to follow the payment plan. Visa, Mastercard, personal checks, and cash are accepted.

We prepare the HCFA-1500 form as an additional service to the patient. Medical claims can be filed with your insurance company either in paper or electronic format. We do not determine the amount of coverage the patient will receive. This is done by the insurance company. You must direct your questions regarding medical benefits to your insurance representative.

"I hereby certify that I have read this financial agreement and agree to accept full financial responsibility for payment of charges that I incur".

Signature: _____ Date: _____

You can agree to assign any payment from insurance to your physician(s) by reading and signing the statement below:

"I authorize all payments due for medical services be made directly to Surgical Associates of New Haven, P.C. by my insurance carrier(s). I permit a copy of this authorization to be used in place of my original signature on the HCFA-1500 form.

Signature: _____ Date: _____

FINANCIAL POLICY

Your medical insurance is a contract between you, the patient, and your insurance company. As a courtesy to you, it is our office policy to bill your insurance company. Please be sure to bring your insurance identification card with you at the time of your office visit.

If you are not a member of an HMO, we request that you pay twenty-five percent (25%) of your bill for office visits at the time of service. In anticipation of payment from your insurance company, we will set aside the remaining balance for thirty (30) days. If your insurance company does not remit payment within this period, you will be responsible for the balance. If you are a member of an HMO, please be sure to bring your referral form and your co-payment with you at the time of your office visit.

If you do not have medical insurance, payment in full must be made at the time of treatment. For your convenience, payment may be made by cash, check, Mastercard, or Visa. If payment of your balance causes a financial hardship, please feel free to speak with your doctor or our patient account representative regarding alternate payment arrangements.