

# STOCKS SURGICAL CENTER, PLLC

## Financial Policy

**Authorization:** I agree to be responsible for my medical expenses regardless of insurance coverage; therefore, I authorize my insurance company, attorney, or other parties to pay directly to Stocks Surgical Center, PLLC, and/or provide any information regarding payment of my bill. If my account should become delinquent, I agree to pay all costs incurred in collecting the account, including a reasonable attorney's fee. I have read, understood, and agreed to the financial policy stated above, and I accept responsibility for any balance not covered by my insurance company.

1. All charges incurred for services in the office, will be due and payable at the time service is rendered. Exclusions to this policy will be those patients whose primary health insurance carrier is Medicare, a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), which pays the physician directly for services or those patients who are being treated for an Industrial Claim.
2. All co-payment, co-insurance and deductible amounts are due and payable at the time of check-in. This policy is in accordance with the legal requirements for collecting patient responsibility amounts.
3. All charges for services incurred in the office or outside the office will become due and payable in full by the patient on day **61** after the date of service. This allows sufficient time to process insurance and to make payment in full of any balance remaining applicable to the deductible or co-insurance amount. Exceptions to this policy would be the same exclusions listed in item #1.
4. Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare may deny payment for services provided and patient may be responsible for payment.
5. We are happy to provide treatment for work related injuries (Workers Comp.). Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment from the patient is expected until we are provided with the information necessary to submit a claim.
6. Our office will treat auto accident patients. We are unable to monitor long-term accounts involving litigation. We require payment, by the patient, at the time of service.
7. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are required to pay the full amount charge upon receipt of a statement from our office.
8. If your insurance is an HMO or carrier that requires pre-authorization for you to be seen in our office, you are ultimately responsible for obtaining that authorization prior to your visit. We will do our best to assist in the obtaining of that authorization; however, it is your responsibility to confirm. If we do not receive authorization, you may be rescheduled or asked to sign a waiver accepting responsibility.
9. A **\$25.00** service charge will be applied to your account for all return checks.
10. Copying medical records for reasons other than our physician referring you to another physician or provider will incur a cost of not less than \$ 10.00. Cost is based on the number of copies and postage and handling.
11. Among others, we are not participating with Tricare, Tricare for Life, Champus, Mamsi, Alliance, Medicaid, Wellpath, and Duke Select. If we do not participate with your insurance you are considered a self-pay patient and payment is due in full at the time services are rendered.
12. Be advised that the charges you incur from Stocks Surgical are our physician's charges. If you are scheduled for surgery, procedures, tests or biopsies etc., you may receive additional charges from other facilities involved in your treatment. The patient is responsible to call their insurance company to verify participation with any other facilities involved in their treatment.

I authorize the physician in charge to administer medical care as is necessary, including allowing release of x-ray and other medical reports on my physical condition to any party involved in my treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_