Patient Financial Agreement

To understand our billing practices, please review the information below in the section that applies to you.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. However, we will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. Any remaining balance after your insurance pays is due upon receipt of your statement. If your insurance company requires a referral and/or pre-authorization, you are responsible for making sure they have been obtained. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company and more liability for you. If there are any changes to your insurance information, please notify our office immediately.

Deductibles/Coinsurance/Copayments: We may contact you prior to your procedure to discuss prepayment of your deductible, coinsurance or copayment. Deductibles, copayments, and coinsurance amounts over $300.00 will be collected at the time you check in for your procedure/surgery. These are required by your insurance company and agreed upon by you when you accept their insurance. We will estimate your costs to the best of our ability, but additional charges may be incurred based on the actual procedures that were performed. It is your responsibility to know and understand what your insurance will cover, which procedures are non-covered by your insurance policy (review your benefit summary), and procedures that are denied or not authorized by your insurance. We strongly encourage you to personally contact your insurance company about your upcoming procedure.

Medicare: You are responsible for your coinsurance amount and non-covered services. For Medicare Advantage Plans, copayments will be collected at the time you check in for your procedure/surgery.

Cosmetic Surgery: We require that all cosmetic surgery be paid in full prior to your date of service.

Workers Compensation and Accident or Liability: We will bill your claim for you, to the applicable insurance. If the claim is denied or benefits are exhausted, we will bill your private insurance company. For this reason, your private insurance information is required to be on file with CSC. You will be responsible for any unpaid balance.

Self-Pay or No Insurance: We will estimate your costs to the best of our ability, but additional charges may be incurred depending on the actual procedures that were performed. The minimum amount required to be paid prior to the date of service is 50% of the estimated cost of the surgery. Payment arrangements for your remaining balance must be made before the date of service and are subject to approval by the CSC Director.

General Information: Payments can be made by cash, check or credit card. A $25.00 fee will be assessed on all NSF checks. Accounts 90 days past due are subject to collection proceedings, and you will be responsible for all collection costs and interest fees. If it's deemed that you are due a refund, we will refund on overpayments greater than $5.00.

Other Bills: CSC's charges are for our facility only. You will receive a separate bill from your physician. You may also receive bills from the anesthesiologist, pathologist, laboratory, and for durable medical equipment (i.e. crutches, braces, walking boots, etc.).

Communication: As the patient or responsible party, I hereby consent to receiving emails and auto-dialed and/or artificial or pre-recorded collection or health-care related message calls and text messages to my email, cellular phone number and any other telephone numbers, as applicable, provided during any interaction, agreement or communication with the facility, its independent contractors, and/or their affiliates, agents and contractors, including any of their billing or account management companies and/or debt collectors

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Print Name **Date**

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Patient or Guardian Signature **Date** **Witness Signature** **Date**

(Place patient identification label in this box.)