Statement of Financial Responsibility – ALL INSURANCE

Assignment of Insurance Benefits

I hereby authorize direct payment to Surgery Center at Hamilton of any benefits otherwise payable to me or on my behalf for the procedure(s) performed at Surgery Center at Hamilton, at a rate not to exceed Surgery Center at Hamilton's regular charges. This Assignment of Benefits is valid for all insurance companies and programs, including Medicare.

Authorization for Release of Information

I authorize Surgery Center at Hamilton to release medical information concerning the procedure(s) performed at Surgery Center at Hamilton as may be requested by third party payers in order to process payment of any claims. I also authorize Surgery Center at Hamilton to release information (including information regarding communicable or venereal disease) to my insurance company, peer review or hospital if transferred for follow-up care.

Alf Insurance Patients

Surgery Center at Hamilton has agreed to accept the amount or percentage that your insurance carrier has agreed to pay for your surgical procedure(s). This amount does not include any necessary co-payment, which remains your responsibility for payment on the day of surgery.

If you have secondary insurance coverage, we will bill that carrier for the balance. If you do not have secondary coverage, we will write off the balance and you will not be billed any additional amount. You will be held responsible for the full charge if your insurance denies for preexisting conditions, non-compliance with information requested by your carrier, or for worker's compensation or motor vehicle charges should your claim be denied as unrelated.

Please be aware that if we are non-participating with your insurance carrier, you may receive the reimbursement check for the facility's fees. Do not deposit the check. You must endorse the check and forward it *with accompanying explanation of benefits form* to the center at the above address. Your insurance carrier will inform the center that this has occurred. If you do not turn over the check and explanation of benefits, you will be responsible for the entire bill. If, however, you deposited the check in error, you must Immediately forward a check made payable to the "Surgery Center at Hamilton" to our office.

Medicare Patients

Surgery Center at Hamilton is a participant in the Medicare Insurance program. We accept assignment for your facility fee. To comply with Medicare regulations, you will be billed and are responsible for payment of your yearly unsatisfied deductible and any applicable co-insurance amounts. If you cannot afford to pay these balances, proof of indigence must be provided to determine your financial requirement. If you have secondary insurance coverage, we will bill that carrier for the balance.

Credit Policy

In the event that this account is placed with a collection agency, you agree to be responsible for the collection fees, reasonable attorney's fees and court costs.

Default Policy

If there is a default in any one payment (no payment when due) there will be an added 25% collection or attorneys' fee, plus all costs, if your account goes to a collection agency or collection attorney for collection or litigation. In addition, interest at 1.5% will be charged monthly to the total outstanding balance.

I have read and understand the terms of this policy statement.
I also understand that it is my responsibility to be knowledgeable regarding my insurance coverage and to provide accurate insurance information.

Patient Signature (Parent or Guardian, if minor) Date

Witness Signature Date

SURGERY CENTER
,1 HAMi.TON

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Case:

Dr.: *
Pt: *

Acct:·
DOB: *
Age: • Sex:•