Financial and Office Policies

(Initial each line)

_____ All professional services rendered by University Surgical Associates, PC are charged to the patient. We will gladly file a limit of two insurances for you. However, patients are responsible for all fees regardless of insurance coverage.

_____ All co-pays, deductibles and non-covered charges are due at the time of service, regardless of who brings the patient in for his/her visit. We accept cash, checks, Visa, MasterCard and Discover for your convenience. All debit transactions can no longer be voided same day but a refund check will be cut at the end of the business week for all transactions prior to Thursday of each week.

_____ **All patients without insurance will be charged entire visit before seeing the physician. If surgery is recommended, you will be obligated to pay a required down payment by speaking with the financial manager. We also have a payment plan called CareCredit that allows you to start treatment today and spread payments over time.**

_____ Most insurances do not pay for everything. Some services will not be covered and is the responsibility of the patient.

_____ I must give the office a 24 hour notice upon cancellation of my appointment. I understand that if I miss my appointment without notice of cancellation, I will be billed $25.00 for a missed follow up appointment and $50.00 for a new consultation. **I also understand that my insurance company cannot be billed for this and I will be responsible for payment of these charges.**

_____ It is the patient's responsibility to know your insurance benefits and whether the physician you see here is or is not a preferred provider. Patients must provide accurate and up-to-date account information for timely insurance and addresses for statements.

_____ In order to release medical records, we must have a release signed by a parent or guardian on file.

_____ There is a $15.00 per policy fee and a 48 hour waiting period on all medical forms, blue cards not associated with a check-up and medical record copying. Please check with the office staff in advance on the cost for each request.

_____ There is a $30.00 fee on any returned checks.

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, University Surgical Associates, PC has provided or will provide myself or my dependent with professional services and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and of my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand that any expense incurred by University Surgical Associates, PC in its effort to collect claims will be added to my bill and become my responsibility.

When you pay by check, you expressly authorize this merchant or its agents, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee not to exceed the state maximum legal limit.

I hereby authorize the physicians of University Surgical Associates, PC to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.