Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Florida Surgical Clinic LLC
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Thank you for choosing Florida Surgical Clinic LLC as your health care provider. We are committed to providing you the best available medical care. Our staff will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy and assignment of benefits as well as complete our Patient Information Form prior to seeing the physician. Payments for service are due at the time services are rendered. We accept check, Visa, MasterCard, American Express, and Discover. We will be happy to help you process your insurance claim for reimbursement. In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with most local managed care plans. We will follow their guidelines for reimbursement and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.

2. All charges are your responsibility -- whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or limit your coverage by design.

3. Fees for these services, along with unpaid deductibles and co-payments, are due at the end of treatment.

4. If you have a high deductible health plan, we may collect your deductible before your surgical procedure is performed.

5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all, if your insurance does not pay, you are responsible for payment.

6. If your insurance company does not pay in full within 60 days, we require you to pay the balance by check, Visa, MasterCard, American Express, or Discover.

7. Returned checks and balances older than 90 days are subject to collection agency placement, collection fees, and reasonable attorney's fees. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we may assist you in the management of your account.

The Florida Surgical Clinic LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

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You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Florida Surgical Clinic LLC, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to the Florida Surgical Clinic LLC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize the Florida Surgical Clinic LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize the Florida Surgical Clinic LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Self-Pay

If for whatever reason I do not have health insurance, I will be responsible for services rendered here at Florida Surgical Clinic LLC. I agree to pay Florida Surgical Clinic LLC, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Cancelled Check Policy

Cancelled or bounced checks used to pay for services rendered by the Florida Surgical Clinic LLC will be assessed a fee of 75 dollars.

Patient/Guarantor Signature _____ Date _____

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Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies. However, you must call at least two (2) business days prior to canceling your appointment. If you arrive but do not have the proper paperwork, identification, or unable to pay the required payment your insurance plan requires you to pay at the time of the visit, it will be considered a "No Show" visit. It is the patient's responsibility to know what is required payment by the insurance plan they have chosen. A "No Show" visit is when the patient is unable to complete an appointment with the physician, nurse practitioner, or registered vascular technologist. No shows will be assessed a fee of $75.00 dollars.

If you have a surgical procedure scheduled with the surgeon, you must contact the clinic four (4) business days prior to procedure to cancel the procedure or there will be a $300.00 no show fee. This is due to blocking off the surgeon's time, reserving a procedure room/operating room, renting or prepositioning equipment, the amount of man hours and personnel involved in scheduling a procedure.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Lifetime Authorization

I hereby assign all medical and surgical benefits allowable and otherwise payable under my current insurance policy for services rendered and authorize and direct my insurance carrier(s) to issue payment directly to Florida Surgical Clinic LLC. I understand that I am responsible for any amount not covered by insurance, including applicable co-payments, deductibles, non-covered services, and unauthorized services, and agree to pay in a current manner.

I understand that Florida Surgical Clinic LLC does accept assignment for Medicare and payments will be directed to Florida Surgical Clinic LLC.

Should my account be referred for collection procedures, I also agree to pay reasonable attorney's fees and collection expenses.

I certify that I have read and understand the above, and as the patient, guarantor, or patient's responsible party, agree to and accept these terms.

_____ _____

Signature of Patient/Responsible Party Date

_____

Print Name/Relationship