

Cary Surgical Specialists, PC Financial Policy

Please read and sign the following policy to avoid any misunderstandings. If you have any questions, please ask for clarification.

1. We require a current copy of your insurance card at check-in; otherwise payment will be expected at time of service.
2. All co-pays, co-insurances and deductibles are due at time of service.
3. As a courtesy to you we file most primary insurances, however if you have a secondary insurance that is not on our list of contracted providers we would not file your secondary claim. You would send them a copy of your primary carriers Explanation of Benefits. It has all the information required to process your claim.
4. Please see our list of participating insurance companies. If you have insurance not on our list you may still have “out of network” benefits. Call your insurance company and ask what your options would be “out of network”. Give the doctor’s name; he may be listed under a contracted pricing company.
5. Please realize that if a company deems service “non-covered” you are responsible for payment.
6. Medicare will only pay for services that are deemed “reasonable and necessary”, therefore you will be asked to sign a waiver if we determine that your service would likely be denied, and you therefore would be responsible for those charges.
7. HMO, POS etc. plans: We request when an appointment is scheduled that (if required) the primary care physician fax a insurance authorization before the appointment date; however it is ultimately your responsibility to make sure the authorization has arrived before your service or you may be asked to re-schedule.
8. Please be aware that we do not participate with Tricare or Champus in either “participating” or “non-participating” form; therefore they may not process your claim if you file it yourself. Payment is expected at time of service.
9. All balances are due and payable within 90 days of service; this will allow sufficient time for insurance to process and for you to respond to billing statements.
10. A workman compensation form is required at check-in for any work related injuries. These are available upon request.
11. We do not bill for accidents involving litigation. You will be required to pay at time of service.
12. Self pay patients are asked to pay 50% of any surgery estimates prior to surgery.

13. If you have any deductibles that have not been met prior to surgery. Payment for these deductibles are due the day prior to scheduled surgery date.
14. If you have applied for Medicaid, you must show proof within 30 days or we are not obligated to file your claims, and you will be considered self pay until that proof is provided.
15. We request 24 hour notice if you are canceling an appointment.
16. All Medical-form completion will obtain a charge of \$10.00 per form request. If additional information is needed, that cannot already be found in the chart in order to complete the requested form, a schedule visit may also be required. Once all pertinent information is received, the form will be completed with 7-14 days of submitted payment.
17. Responsibility for any service to minor children rests with the parent seeking treatment unless a court ordered judgment is in place.
18. Before the scheduling of any surgery, please check your dates, we charge \$20.00 if you reschedule your surgery.
19. Please be aware that services you receive in the office or hospital may involve other medical parties, therefore you may have additional charges such as lab, pathology, anesthesia, etc..
20. Any return check by the bank for "NSF" or "closed account" will be charged a \$25.00 service fee
21. Patients are seen by appointment time, not arrival time.

Authorization:

I agree to be responsible for my medical expenses regardless of insurance coverage. I authorize my insurance company, attorney or others parties to provide any payment information regarding my bill and make payment directly to Cary Surgical Specialists, PC. I agree to pay all costs incurred if my account should become delinquent, including reasonable attorneys fees. I have read, understood and agree to this financial policy and I accept full responsibility for any balance due.

I authorize the physician in charge to administer medical care as is necessary, and allow release of medical records and x-rays to any party involved in my treatment.

Signature _____

Date _____