SURGCENTER HUDSON, LLC

5700 DARROW ROAD, SUITE 109 • HUDSON OH 44236

Phone: (330) 655-5460 Fax: (330) 655-5461

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient:

Thank you for choosing us as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our billing department or Administrator.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard and Visa. We will submit an insurance claim on your behalf. You must notify us immediately if your insurance information changes.

You must understand and sign that you acknowledge the following:

1. Your insurance policy is a contract between you, your employer and the insurance company.
2. You have the right to waive your insurance at any time. If you do not inform us of your insurance carrier information at the time of service, you are voluntarily waiving your right to use your insurance. You will be responsible for all fees incurred at the time of service.
3. **You are responsible for knowing your insurance benefits.** What are non-covered services in your plan? What is your deductible and co-payment for outpatient surgery? Does your plan require pre-certification? *Even though we may not be participating with your insurance company, you will be responsible for your in-network co-insurance and/or deductible.*
4. If your insurance carrier does not pay in full within 30 days, our billing service will contact them.
5. **If your insurance carrier sends the reimbursement check directly to you, please endorse the check and mail it along with your Explanation of Benefits to us.** Compliance with this request will allow us to process the payment to your account quickly and efficiently.
6. You are responsible for any deductible and/or co-insurance that will be applied to SurgCenter Hudson charges. Your surgeon, anesthesia fees and pathology fees are not included in SurgCenter Hudson charges.
7. Returned checks are subject to a return check fee of $25.00.
8. If your account goes to Collections, you are responsible for any Collection fees, Legal fees or Court costs.
9. I am aware that my surgeon may own an interest in SurgCenter Hudson. I have decided to have my surgery at SurgCenter Hudson.

If you have any questions or concerns, please contact our billing service so that we can assist you in the management of your account.

_____ _____

Signature of Patient/Representative Date

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to SurgCenter Hudson, the amount due me for Medical Benefits under this claim.

I hereby agree to pay SurgCenter Hudson all fees incurred by the patient, not covered by my insurance's in-network benefit level.

Patient/Representative Signature:_____ Date:_____

FOR MEDICARE CARDHOLDERS ONLY:

MEDICARE - MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf.

Signature:_____ Date:_____
(Patient or Authorized Representative)

1. If the beneficiary did not sign this form, what is the relationship of the signer to the beneficiary?

_____

2. If the beneficiary did not sign, please state the reason.

_____