General Information for Our Patients

TO ALL PATIENTS:
We ask that all patients pay for their office visit at the time of service. Unless you have made prior arrangements made through a payment plan agreement or we participate with your insurance plan. We ask for 24 hour cancellation of scheduled appointments, or a $50.00 fee will be billed to the patient.

RETURNED CHECK FEE:
I understand and agree that if any payment made by me or on my behalf by check is returned from the financial institution as unpaid, in addition to the original sum, I am responsible and agree to pay a $50.00 returned check fee. A copy of this agreement may be used in place of an original.

ASSIGNMENT OF BENEFITS:
I certify that the insurance information provided with regard to my insurance coverage is correct. I further authorize the release of any information necessary, including medical information for this or any claims generated from this office for covered services provided to my insurance carrier. A copy of this authorization may be used in place of the original. I hereby assign the benefits payable for covered services to be paid directly to "Belmont Surgery Center L.L.C."

MEDICARE PATIENTS:
I authorize the holder of medical or other information about me to release to the Social Security Administration of its intermediaries of carriers any information for all Medicare claims. I assign the benefits payable for covered services to "Belmont Surgery Center, L.L.C."

GUARANTEE OF PAYMENT:
I understand and agree that I am responsible for payment of all professional services rendered now and in the future by this practice. If I am insured and this practice is a participating provider with my insurance, I am financially responsible for all payments my insurance company identifies as my responsibility. I agree to pay all balances due in a timely manner (within 30 days). A copy of this agreement may be used in place of an original. If the practice is not a participating provider, I authorize payment of medical benefits from all insurance reimbursements to Belmont Surgery Center, L.L.C.

COLLECTION FEE:
If I do not pay all balances owed by me in a timely manner (within 30 days), the undersigned hereby agrees to pay 18% interest per annum on said balances to accrue from the date of professional services were originally rendered: plus attorneys fees which are hereby stipulated to be 33 1/3 % of such outstanding balance whether suite is filed or not, plus court costs. If the undersigned fails to pay promptly for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining credit information and/or locating the undersigned as may be necessary,

In the event prompt payment is not made by the undersigned, the undersigned understands that personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "HIPAA" regulations. A copy of this agreement may be used in place of an original.

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Signature of Patient or Responsible Party Date