# Arundel Ambulatory Surgery Center

## FINANCIAL POLICY

Arundel Ambulatory Surgery Center (AASC), hereafter referred to as Healthcare Providers, is committed to providing the best possible care for you. If you have medical insurance, we will help you to receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy. This form with your signature and a copy of your insurance card will be included as part of your medical record. This information will then allow us to bill your insurance company.

If your insurance pays all or part of the center's and/or physician's charges, the center and/or physician that rendered services to you is authorized to submit a claim for payment to your insurance carrier but is not obligated to do so unless under contract with the insurer or bound by a regulation of a state or federal agency to process such a claim. All copayments are due at the time of your appointment.

**All checks returned by the bank will be assessed a $35.00 fee. It is our collection process to turn all unpaid accounts over for collection activity after 60 days.**

**MEDICARE CERTIFICATION AND AUTHORIZATION:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information 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.

**FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT:** If my insurance/manage care plan rejects my bill or pay partial payment for my treatment, I will be financially responsible for any portion of my treatment that my insurance/managed care service plan does not cover, and I agree to pay all uncovered charges. I understand that all uncovered charges are due and payable upon receipt of my statement.

_____I understand that separate bills may be generated for each of the following services, as applicable: physician provider, provider facility fee, anesthesia, laboratory, and pathologist.

**Should any account be referred to an attorney for collection, the undersigned agrees to pay attorney fees of 25% for collection activities. All delinquent accounts will be charged interest at a rate of 1½% per month.**

**PATIENTS WITH NO INSURANCE:** Self-pay patients are required to pay in full all charges incurred during the visit. If special arrangements need to be made, a payment contract can be arranged for you with our billing office. We gladly accept Mastercard, Visa, debit cards, cash, and checks.

_____I acknowledge that I have received the following prior to my procedure:

-AASC privacy practices
-Patient Bill of Rights
-Description of Maryland State Law Advance Directive Policy
-Physician ownership interest

_____ I consent to AASC use and disclosure of my protected health information for treatment, payment, and health care operations. I understand that I have the right to revoke this consent in writing, except where AASC has already made disclosure in trust, based on my prior consent.

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I certify that I understand the contents of this form. Additions, deletions, or alterations to this printed form are invalid. A photocopy or facsimile of this document shall be valid as the original.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Guarantor Signature Date

_____ _____
Witness Date

Patient Label