PULASKI SURGERY CLINIC
FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Pulaski Surgery Clinic (“PSC”). We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage. By signing this form you authorize PSC to release the necessary information in order to complete and process your insurance claims.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. **This arrangement is part of your contract with your insurance company.**

3. Non-covered services. By signing this agreement, you understand that some, and perhaps all, of the services you receive may not be covered by your insurance or not considered reasonable or necessary by Medicare or other insurers. You agree to pay for any services which have been determined by your insurance plan to be “non-covered”. Payment in full for these services is generally due at each visit.

4. Updates. Our staff will ask you to verify your billing information at each and every visit. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.

7. Nonpayment. If the account is not **paid in full** after two monthly statements or a suitable payment arrangement has not been established, the account will be reported for collections.

8. Missed appointments and Late Arrivals. You will be charged $25 for a missed appointment if you do not notify us at least 24 hours prior to your scheduled appointment time or if you are more than 15 minutes late for your scheduled appointment. Help us to serve you better by keeping your regularly scheduled appointment and arriving at least 20-30 minutes prior to your scheduled appointment time.

9. Returned checks (NSF). You will be charged a $25 processing fee for any personal check returned for nonpayment.

10. Workman’s Compensation. If you were injured at work and have reported the injury to your employer, you must provide our office with the following information: Date of injury, Claim number, Insurance Company with address and phone number, and Adjusters name, phone and fax. If you do not have the above information, you will be required to provide your own insurance information until workman’s compensation information is provided. If you are not insured, you will be considered self-pay.

11. Automobile Accident. If you were injured in an automobile accident, you must provide an open claim number from your insurance company. If your claim includes attorney representation, we require a Letter of Protection from your attorney ensuring payment to our office for services rendered. You will be responsible for all unpaid balances at the time of service.

12. Forms. All forms requiring completion by our medical staff and/or providers will be subject to a $20 form completion fee per set.

I have read and understand the payment policy and agree to abide by its guidelines:

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Signature of patient or responsible party Date