GWINNETT SURGERY CENTER, LLC
FINANCIAL POLICY

Patient Name: _____
ACCT: _____
Date: _____

Procedure: _____
Date of Procedure: _____

Procedure Fee Estimate: _____
Deposit Due: _____
Collected & D.O.S. _____

You have been quoted for the procedure(s) listed above. If any additional procedures are added, you will be charged accordingly.

YOUR PROCEDURE FEEES ARE YOUR PERSONAL OBLIGATION REGARDLESS OF INSURANCE COVERAGE. If correct and accurate insurance information is given, we will file your insurance for you. You will receive monthly statements until your account is paid in full; payment policy is as per policy of ***Gwinnett Surgery Center, LLC***. We will attempt to verify your insurance prior to your procedure. This is only a statement of benefits and not a guarantee of coverage. If your insurance covers at other than 100%, you will be required to pay the amounts not covered before your procedure. This may be paid by cash, check or credit card.

If a referral is required from your primary care physician, it is your responsibility to obtain this referral. If you have an attorney handling your bills due to a motor vehicle accident, personal injury, etc., you may obtain copies of your bills by contacting us; however, we are not a party to your lawsuit and require that you pay your bills in full.

We require that patients agree to pay reasonable attorney's fees and costs should it become necessary to enforce payment of a past due account. We also require that patients inform us should there be a change in address, phone number or employment.

I hereby authorize the Center to furnish information to insurance carriers concerning my conditions and treatment, and I hereby assign to the Center all payments for medical services rendered to myself of my dependents.

THE FACT THAT I MAY NOT BE COVERED BY INSURANCE DOES NOT RELIEVE MY PERSONAL OBLIGATION TO PAY ALL PROCEDURE CHARGES.

I have read and agree to all terms and conditions heretofore mentioned and acknowledge receipt of a copy of this agreement.

_____ _____
Signature Date

FOR OFFICE USE ONLY

Insurance Verification Yes___ No ____ Effective Date of Coverage: _____ Date: _____ Time: _____ By: _____

Deductible Satisfied: Yes___ No ____ Deductible Amount: _____ Out of Pocket Satisfied: Yes___ No ____ Coverage %: _____%

Insurance Representative: _____
HMO___ PPO ____

Pre-cert Required? Yes___ No ____

Insurance Company Mailing Address: _____

Patient Notified of Deposits? Yes___ No ____
Date & Time: _____ In_____

Prepared by Medical Management Associates, Inc.
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