



## FOUR SEASONS SURGERY CENTERS PATIENT ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Four Seasons Surgery Center (FSSC) will bill your insurance company as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event that services rendered are not covered by your insurance company, we will require that you remit payment to FSSC. Additionally, if your insurance company does not remit payment in a timely manner (within 60 days from the time your claim is billed), we may transfer the balance to your responsibility and require that you remit payment to FSSC for all outstanding insurance balances over 60 days. The outstanding balances may include, but are not limited to:

- Annual deductibles, co-payments not paid at the time of service, and services that are not covered by your health plan.

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that will be provided to you. As a courtesy, we will contact your insurance company for authorization for services. However, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services prevent delays in treatment, and expedite payment for your services.

We frequently experience difficulty with insurance plans in receiving timely payment. Our policy is that we will bill your primary and secondary policies. If we do not receive payment within 60 days of the date we bill your insurance, then we may transfer the balance to your responsibility and require that you remit payment to FSSC. To prevent this, we suggest that you stay in communication with your insurance company to assure they are paying for services we render. Often, insurance companies are more responsive when they are contacted by their policy holders. In addition, should our billing office contact you for assistance in obtaining payment from your insurance company, your prompt response to their calls would be appreciated. Our billing service may be reached at (702) 949-50121 and they will work with you in obtaining payment on your claims.

**Return Check Policy:** If a payment is made on an account by check and the check is returned by the bank i.e. for Non-sufficient funds (NSF) or Account closed (AC) the patient or responsible party will be liable for the original amount of the check in addition to a twenty-five dollar (\$25.00) Service Charge. Payment is required within fifteen (15) days.

We require timely payment when you receive your monthly statements. Balances are due upon receipt of your statement. If payment is not received within thirty (30) days, your balance due will be charged to your credit card. Please provide the following credit card information. You will be notified in advance of any charges made to your credit or debit card.

Credit Card: MasterCard/Visa/Other: \_\_\_\_\_  
Expiration date: \_\_\_\_\_  
Card Number: \_\_\_\_\_  
Name on Credit Card: \_\_\_\_\_  
Address credit card statement is mailed to: \_\_\_\_\_  
\_\_\_\_\_

Any accounts assigned to a collection agency will be charged a service fee based on the amount sent for collections. i.e., balances up to \$100.00 will be charged \$25.00; up to \$200.00 will be charged \$50.00 etc.

**All patient balances that are past due will accrue a finance charge of 1.5% of your outstanding patient-due balance. Any finance charges charged and collected in excess of applicable state law shall be returned.**

I have read and understand the policy stated above.

I understand and agree that I (or the person financially responsible for me) am financially liable for all services rendered and will pay my outstanding balance within 10 days of receipt of my monthly statements. I also understand that if my insurance plan does not pay FSSC within 60 days of the services billed, the balance will be transferred to my responsibility and payment will be due at that time.

\_\_\_\_\_  
Patients Printed Name

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
Responsible Party's Printed Name

\_\_\_\_\_  
Responsible Party's Signature

\_\_\_\_\_  
Date