

Watauga Surgical Group, P.A.
965 State Farm Road
Boone, NC 28607
Telephone (828) 264-2340 Fax (828) 262-0731
Patient Accounts (828) 264-1653

FINANCIAL POLICY

Watauga Surgical Group, P.A. is committed to providing quality health care to all its patients. In order to do that, we feel it is best to establish an account policy between our patients and our office to avoid misunderstandings. Watauga Surgical Group expects patients to understand their insurance benefits and to assume responsibility for their bills. Our billing staff is available to discuss your account with you at any time.

1. **FINANCIAL RESPONSIBILITY.** I, the undersigned, hereby understand and acknowledge that it is the policy of this office that payment is made at each visit and I am responsible for payment of all services rendered in my behalf. If the treating physician(s) is a participant in an HMO, PPO or IPA, of which I am a member, I agree to pay any co-payment required and any fees for uncovered services that any medical insurance, HMO, PPO, or other payer does not pay.

INTEREST: I agree to pay interest at one percent (1) per month (twelve percent (12%) APR) upon any outstanding balance over ninety (90) days. I understand that if my account is unpaid after ninety (90) days, and no payment arrangements have been made with this office, my account will be subject to the following collection process: 1) My account will be turned over to an outside collection agency for collection, 2) This process may include reporting to the credit bureaus, 3) Patients will be dismissed from Watauga Surgical Group.

2. **INSURANCE MATTERS.** I understand the following concerning insurance:
1. We will file your insurance, however we **MUST** have a copy of your insurance card in order to file. At the time of service, you will be responsible for any and all co-pays, deductibles, and co-insurance amounts.
 2. All insurance changes must be given to us at the **time of service**. If your insurance changes are not provide at time of service, you will be responsible for any charges.
 3. **SURGICAL PROCEDURES:** Watauga Surgical Group will verify benefits on each patient who will be undergoing an elective surgical procedure according to the insurance information provided. Patients will be asked to pay any remaining deductible and co-insurance, up to the contractual rate, prior to their surgical procedure. Failure to pay the deductible and co-insurance may result in cancellation or delay of surgery.
3. **RETURN CHECKS.** A service charge at the current statutory rate will be applied to your account for all return checks. Once a return check has been received, all future payments must be made with cash, money order or cashier's check.
4. **MEDICARE and/or MEDIGAP PATIENTS.** I hereby request that the payment of authorized Medicare and/or Medigap Benefits be made on my behalf to Watauga Surgical Group, P.A. for any services rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.
6. **AUTHORIZATION FOR MEDICAL PAYMENTS.** I hereby authorize payment of medical benefits to Watauga Surgical Group, P.A. for services rendered.

I, the undersigned, further state that the foregoing Financial Policy has been carefully read, and that I understand the contents thereof, and have signed of my own free and voluntary act, and have not been influenced in executing this agreement unless or until withdrawn by me in writing.

_____ [SEAL]
Patient Signature (or Parent if Patient is a Minor)

_____-_____-_____
Dated

Witness

Copy Provided to Patient