SURGICAL SERVICES, PC
510 E. Bloomington St.
Iowa City, IA 52245-2803
(319)338-9247

Rick A. Shelman MD, FACS  Robert R. Radcliffe MD, FACS

**Welcome to our practice. We are committed to providing you with quality health care.**

## *FINANCIAL POLICY*

This agreement is between Surgical Service, PC, (SSPC – the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills. By executing this agreement, you are agreeing to pay for all services that are received.

It is your responsibility to know the requirements of your insurance company. This includes participation, referral requirements, second opinion, prior approval, pre-certification and out-patient and / or in-patient status. You are also responsible for all co-payments, co-insurance and insurance deductible as required by your insurance plan. You must be aware of any pre-existing wait period, a ridered condition or waiting periods outlined by your insurance carrier.

### Monthly Statements

If you have a balance on your account, we will send you a monthly statement. It will show current balance and insurance adjustments/payments. Unless Surgical Services, PC approves other arrangements in writing, **the balance in full on your account is due and payable within 60 days from the date of service.**

### Insurance

Insurance is a contract between you and your insurance company. We are not party to this contract in most cases. We gladly submit your claims and will assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and some may not cover 100% of the fees for our services. If your insurance company requires a referral and / or preauthorization, ***you*** are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower or no payment from the insurance company. Please remember, that although we will assist you with your claim, you must assume full responsibility for payment.

### Workers Compensation

We require written approval or authorization by your workers' compensation carrier. **Surgery will not be scheduled until we have received a letter from the insurance carrier approving your claim.** If your claim is denied you are responsible for payment in full.

### Uninsured Payment Options

Payment is required in FULL from the date of service, unless other arrangement have been made, in writing, with Surgical Services, PC. A 15% discount is given if your balance is paid in full on the date of service.

**Extensive Treatment and/or Large Balance:**
We understand that medical bills can add up quickly and sometimes patients aren't able to pay the balance in full within the 60 days. The billing department is able to further discuss your payment options.

**Divorce**
In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs it is the authorizing parent's responsibility to collect from the other parent.

**Past Due Accounts**
If your account becomes past due, we will take necessary steps to collect this debt, which could result in turning your account over to a collection agency or attorney.

**Payment Options**

___ Cash
___ Checks
___ Credit/ Debit Card
___ Money Order

- Required Payments: **All co-payments must be paid at time of service.**
- **Failing to pay co-payment and deductibles could result in loss of your insurance coverage.**

**We understand there will be some exceptions to these policies and are willing to work with you whenever possible.**

**SUGGESTED MONTHLY PAYMENT**

| | |
|---|---|
| $0-$50 | Payment in FULL |
| $51-$150 | 2 monthly payments |
| $151-$300 | 3 monthly payments |
| $301-$500 | 4 monthly payments |
| $501-$2000 | 6 monthly payments |
| $2001- above | 12 monthly payments |

**EFFECTIVE DATES**
**Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.**

**Patient's Name:**_____ **Date:** _____

_____ **Date:** _____
**Responsible party, if not the patient**

_____ **Date:** _____
**Signature**