

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of Surgical Associates of Sussex County, PA's Notice of Privacy Practices with an effective date of April 1, 2003.

Name of Patient \_\_\_\_\_

Address of Patient \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

### Financial Policy

I assume financial responsibility for any service that is not approved on my referral (if such form is required by my insurance carrier); any service which is either cosmetic or not covered by my insurer; any visit for which I have not presented a required referral form on the day of service or is a non covered service.

I understand I am responsible for DEDUCTIBLE, CO-PAY OR CO-INSURANCE as my insurance plan dictates. I do hereby agree to pay any and all bills for services not covered by my insurance plan. I understand it is the policy of Surgical Associates to add a fee of fifteen dollars (\$15.00) for any co-pay not paid at the time of service. I also understand that if I choose to pay my self pay balance on a payment plan, I will be charged a service fee of one and one half percent (1 1/2 %) interest per month until my balance is paid in full.

I understand it is the policy of Surgical Associates to add a collection fee for any delinquent accounts referred to a collection agency. I understand if my account becomes delinquent and is sent to a collection agency, I will be billed an additional amount of fifty dollars (\$50.00) or twenty percent (20%) of the balance owed, whichever is greater.

As a courtesy to our patients, we will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit second or third insurance claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your particular plan. The patient is responsible to know the rules of their health plan, as we cannot change our coding in an attempt to obtain payment.

I hereby authorize Surgical Associates of Sussex County to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible and non-covered services.

I have read, understood and agree to the above financial policies.

\_\_\_\_\_  
Signature of **Patient** or Responsible Party

\_\_\_\_\_  
Date