# Cumberland Surgical Arts and Associates, PLLC Financial Agreement

*We strive to provide high quality, cost effective care to our patients. Our first priority is to you, our patient. As we are sure you understand, to continue providing care we must receive prompt payment for the services rendered. Your assistance in seeing that your account is kept current is appreciated!*

*Please read the following financial agreement initial, sign, and date at the bottom:*

- This office will accept the following methods of payment for services rendered: Discover/Visa/MasterCard/American Express/Debit Cards/Cash/Cashier's Check. We DO NOT accept personal checks.
- Responsible parties without insurance coverage agree to pay for services at time of visit. All procedures must be paid in full prior to surgery.
- We do accept CareCredit financing to assist with the cost of your surgical treatment in limited circumstances. If you would like to utilize CareCredit financing please discuss this first with our financial counselor to see if your treatment plan meets the criteria. Please understand we do not offer all CareCredit. We do not provide in-house financing or payment plans.
- This office will not be involved with any third-party liability cases. We do not file with automobile or home owners insurance liability policies. Services are to be paid in full by you and you can seek reimbursement from the liability insurance company.
- We are not a provider for Workers' Compensation Plans.
- It is our policy to submit any insufficient funds to the appropriate legal authorities. A $35 charge will be added to your account for each check returned.
- You agree to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. (Please Initial_____)
- In cases of divorced parents, the parent bringing the child will be deemed responsible for payment. We cannot become involved with personal issues between divorced/separated spouses. It is their responsibility to coordinate payment for surgery and see that payment of the estimated patient portion is paid in full prior to surgery. We will not make another party responsible for the account without their written consent.
- All patients are charged the same for services rendered. This office does not accept reasonable and customary charge calculations by outside parties, unless this office is a participating provider. Any adjustments/write-offs will be applied upon receipts of payment and EOBs.
- Patients who do not give 48 hours to cancel a surgery or no show for surgery will be billed a $150 No-Show fee. This is not billed to your insurance company and will not be credited towards future appointments. You may not reschedule until this fee is paid. At doctors discretions you may be discharged from the practice. (Please Initial_____)
- All post-op appointments which are missed (no-show) will be assessed a $10 fee. Missed follow up appointments will be assessed a $50 fee. This also is not billed to your insurance company. If you must cancel your surgical appointment, we require at least 48 hours (2 business days) notice and 24 hours (1 business day) for follow ups and post op appointments. (Please Initial_____)
- If you do not confirm your surgical appointment with a member of our team (must speak to us) prior to 24 hours (1 business day) before your scheduled surgery your appointment will be cancelled. You will also be charged $150 cancellation/no-show charge.
- Some procedures require a deposit to be paid prior to scheduling. Our treatment coordinator will discuss that with you if it is applicable to your procedure.

*Patients with Insurance – Please read the additional policies:*

- The most common misconception concerning insurance is that your policy will cover the total cost of surgical fees charged. Insurance is designed to reduce your out of pocket cost, but usually will not eliminate it entirely. Your portion is due at the time of service.
- Your surgical treatment is not dictated on what your insurance will cover. Together, your surgeon and you create your treatment plan based on what your current medical and dental needs are. We cannot limit your care to just what is covered by your insurance plan. Every plan is different and each insurance company determines what is covered. Just because a particular service is not covered does NOT mean you do not need it.
- Insurance will only be filed for plans that we are provided with at the time of service. We will not "back file/retro-file" any claims. You must provide all insurance information at the time of service. You are responsible for filing any claims with insurance plans we were not made aware of.
- If your insurance policy requires a referral, that must be obtained prior to the appointment. We will not obtain "retro" authorizations for services not authorized in advance by the insurance company. It is the patient's responsibility to know if their insurance plan requires a referral from their primary care doctor.
- If no insurance payment has been received within ninety (90) days of service, the patient is fully responsible for payment of the account. Please contact your insurance company to ensure your benefits are paid on your behalf.
- Any unpaid amount not covered by your insurance must be paid in full by the responsible party no later than 60 days following receipt of the explanation of benefits from your insurance company.
- Due to increases in postage and mail supplies, Cumberland Surgical Arts will only send out ONE (1) billing statement per date of service. It is your responsibility to keep your account current and to update us with address changes as they occur. All account balances must be paid within THIRTY (30) days from the date on the statement.
- If payment has not been made to an account ninety (90) days after receipt of the explanation of benefits, and no contact or appropriate arrangements have been made, the account will be referred to the necessary legal authorities and credit bureau service.

Patient Name:_____
Date:_____

- Any postage returned because you have failed to provide us with the most current address will be added to your account.
- Insurance will NOT be filed for cosmetic surgery procedures. If your surgeon determines that your procedure may be considered medically necessary by your insurance company, then we will assist you in filing the appropriate insurance paperwork. Final determination of medical necessity for insurance purposes is made by your insurance company.
- Insurance coverage will be verified at the time of service. You must provide this office with an insurance card or proof of coverage. If coverage is unable to be verified, you are responsible for all charges incurred.
- Upon verification of insurance benefits, we will attempt to estimate your portion of fees due. You are responsible for any co-insurance amounts prior to surgery. (Please Initial_____)
- We cannot, by federal law, discount your portion as determined by your insurance company.
- If there is any other payment on the responsible parties part or the insurance company's part over the charges submitted, we will refund the difference. This takes about 30 days to process.

Responsible parties with insurance coverage can either:

- File insurance yourself and pay us in full directly the day services are rendered. We will assist you with you paperwork.
- Have us file your insurance. We will only file with 2 insurance plans. Filing of any additional plans will be your responsibility. You must have on the day of your appointment:
  - Insurance card with Subscriber's information
  - Photo ID (We do not file ANY insurance without a photo ID – driver's license, Military ID)
  - The co-payment and deductible (as applicable) the day services are rendered. Co-payment can vary with insurance plans.

*Please read regarding estimate of benefits for surgery:*

- We are not privileged to all insurance plans limitations and exclusions. You, as the beneficiary of the insurance policy, are responsible for knowing all policy limitations and exclusions. The contract for benefits is between you and your insurance company; our only relationship is with you, the patient. We will prepare an estimate of insurance payment and your responsibility. This is prepared using information provided by your insurance plan's representative. We only use the information they provide us with, so if the information is not current, inaccurate, or lacking in detail, that will affect the treatment plan estimate we provide you with. Neither we, nor the insurance company, can guarantee the estimated payment amounts. Please understand that the estimate generated is provided as a courtesy. We will assist you in understanding your benefits, but are not responsible for your benefits or what is ultimately paid by your insurance plan. Any discrepancies should be addressed with your insurance company as they make the final determination of benefits provided, not us. You are responsible for verifying that all waiting periods have been satisfied prior to surgery. We cannot be held to the estimate of insurance benefits, as it is only an estimate based on information provided on the day it is generated. Annual maximums, deductibles, and percentages of coverage may be different on the day of surgery based on care received by other practitioners and the medical necessity of the procedure as determined by your insurance company. Your surgeon does not determine medical necessity for your insurance company, but will assist in providing justification for surgery to your insurance company to assist in determination of benefits. You, as the patient, are ultimately responsible for the full amount of the surgical cost.

*Insurance is filed solely as a courtesy to our patients. Please help us to keep this service available to all patients.*

I, (please print)_____ have read and agree to the above financial policies. I understand it is my responsibility to pay any fees to this office.

Signature_____ Date_____

Relationship (if not patient) _____

*If you have insurance, you must sign below:*

I authorize release of any information relating to this claim. I understand that I am financially responsible for all costs of treatment. I hereby authorize payment of the medical and/or dental benefits otherwise payable to me directly to the below named entities.

*Cumberland Surgical Arts and Associates, PLLC*
*George S. Lee, MD, DDS*
*Jason S. Lilly, DMD*
*Matthew A. Defelice, DDS*

Signature_____Date_____