

Thank you for having your procedure at Northwest Ambulatory Surgery Center. We are committed to your procedure being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The services that you receive and the bill is an agreement between you and Northwest Regional ASC. **It is ultimately your responsibility to see that your bill is paid in full.** Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Northwest Regional ASC within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. In the event a check is returned for any reason, a \$25.00 charge will be made to your account.

Attorney Liens. If you hire an attorney to represent you in a lawsuit, we will accept a signed lien agreement guaranteeing direct payment to our Center for any unpaid balance upon the settlement of your case. As a courtesy to you, we will gladly submit your charges to your attorney. However, all service rendered to you are your personal responsibility regardless of any settlement you may or may not receive.

Regarding Insurance Plans where we are a participating and non-participating provider: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph. If you receive payment made out to you, please endorse the check and forward to us.

Our Center is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with Margo, Business Office Manager at 303-328-3400 x200. If we bill your insurance and reimbursement is 100% denied, we will bill you our Self Pay rates. If you are unsure of self pay rates, it is your responsibility to ask. On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service. If you do not have sufficient funds to cover a check or Debit card transaction, you will be charged \$25.00 per item.

FEES

Court costs including the court filing fee, service fee and e-file fee for summons and complaints, garnishments and transcripts in addition to reasonable attorney fees will be the responsibility of the adult person(s) named on the account. A collection agency fee of 25 percent will also be added to all balances if turned to collections. The collection agency fee will increase to 40 percent if a summons and complaint are filed with the appropriate court or if a process server serves the named adult on the account. A relative over the age 18 may also be served at the responsible adult person(s) residence in absence of adult person on the account.

I have read the *Financial Policy*. I understand and agree to this *Financial Policy*.

Signed: _____

Dated: _____

Prior to my procedure, I acknowledge that I have received and/or read the following documents:

Privacy Notice, Patient Rights & Responsibilities, Ownership Disclosure, and Advanced Directives

Signed: _____

Dated: _____