SURGERY CENTER AT HAMILTON

Statement of Financial Responsibility Agreement

Assignment of Benefits

I hereby authorize direct payment to the Surgery Center at Hamilton of any benefits otherwise payable to me or on my behalf for the procedure(s) performed at the Surgery Center at Hamilton, at a rate not to exceed the Surgery Center at Hamilton's regular charges. This Assignment of Benefits is valid for all insurance companies and programs, including Medicare.

Authorization for Release of Information

I authorize the Surgery Center at Hamilton to release medical information concerning the procedure(s) performed at the Surgery Center at Hamilton as may be requested by third party payers in order to process the payment of any claims. I authorize the Surgery Center at Hamilton to release information (including information regarding communicable or venereal disease) to my insurance company, peer review, or hospital if transferred for follow-up care.

All Insurance Patients

Surgery Center at Hamilton has agreed to accept the amount or percentage that your insurance carrier has agreed to pay for your surgical procedure(s). The amount does not include any necessary co-payment, which remains your responsibility for payment on the day of surgery.

If you have secondary insurance coverage, we will bill that carrier for the balance. You will be held responsible for the full charge or allowed amount by your insurance contract if your insurance denies for preexisting conditions, non-compliance with information requested by the carrier, or for worker's compensation or motor vehicle charges should your claim be denied as unrelated.

Please be aware if we are non-participating with your insurance carrier, you may receive the reimbursement check for the facility's fees. DO NOT DEPOSIT THE CHECK. You must endorse the check and forward it with the accompanying explanation of benefits form to the center at the following address:

1445 Whitehorse-Mercerville Road, Suite 101, Hamilton New Jersey 08619. If you do not turn over the check and the Explanation of Benefits (EOB) you will be held responsible for the entire bill. If, however, you deposited the check in error, you must immediately forward a check made payable to "The Surgery Center at Hamilton" to our office.

Medicare Patients

The Surgery Center at Hamilton is a participant in the Medicare Insurance Program. We accept assignment for your facility fee. To comply with Medicare regulations, you will be billed for and responsible for payment of your yearly unsatisfied deductible and applicable co-insurance amounts. If you cannot afford to pay these balances, proof of indigence must be provided to determine your financial requirement. If you have secondary insurance coverage, we will bill that carrier for the balance.

Credit Policy

In the event that this account is placed with a collection agency, you agree to be responsible for the collection fees, reasonable attorney's fees and court costs.

Default Policy

If there is a default in any one payment (no payment when due) there will be an added 25% collection or attorneys' fee, plus all costs. If your account goes to a collection agency or collection attorney for collection nor litigation. In addition, interest at 1.5% will be charged monthly to the total outstanding balance.

I have read and understand the terms of this policy statement. I also understand that it is my responsibility to be knowledgeable regarding my insurance coverage and to provide accurate insurance information.

Signature **X**_____ Date: _____

I am the ☐Patient

If: ☐Guardian ☐Legal Rep Printed Name:_____

Surgery Center at Hamilton Witness: _____ Date:_____