Hand Surgery Specialists of Nevada

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FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

All fees for medical care are based on the usual, reasonable, and customary fee charged in this area by Physicians of equal training and experience.

Copayments, coinsurances and deposits for medical services rendered is due at the time of service unless prior arrangements have been made. Non-payment may result in rescheduling your appointment. All the forms must be filled out in their entirety.

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your insurance carrier and final responsibility for payment of your account rests with you.

The exception to the above is for those patients with injuries that are work-related and are covered by Workers Compensation. These patients are not responsible for their bills, unless their claim is denied. This is why we need information about your private primary insurance so that the billing process can go smoothly if Workers Compensation denies your claim.

Prior authorization obtained for procedures and therapy by this office; on your behalf, do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions and your insurance carrier determines final payment. **A deposit is required if you are being scheduled for surgery.** If an assistant is required at the time of surgery, to improve the quality of your surgical outcome, the assistant's fee is in addition to the surgical centers, hospital, and anesthesiologists for surgical procedures.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medicaid, Veteran's Administration, or other designated payer of medical benefits to my doctor for clinical, surgical and/or therapy services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A 35% collection fee will be added to unpaid balances that are sent to a collection agency. 1.5% interest will be accrued monthly and will be added to all unpaid monies owed. A photocopy of the assignment is considered as valid as the original. There will be a $35.00 fee for all returned check items.

I also authorize my doctor to release my insurance carrier, Medicare, Medicaid, Veteran's Administration, or other designated payer of medical benefits any medical information about me needed to determine these benefits or the benefits payable for service.

I hereby consent to and authorize medical treatment, tests, procedures and or therapy performed in the office that my Physician deems advisable and necessary based on his or her judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

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Patient/Guardian Signature Date

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Print Name of Signature