Austin Surgeons

FINANCIAL POLICY

Thank you for selecting Austin Surgeons, PLLC as your healthcare provider. Our staff will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician. Payment for services are **due at the time services are rendered**. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check, VISA, MasterCard, Discover and American Express.

1. Your insurance policy is a contract between you, your employer and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary charges". We are, however, contracted with most managed care plans. Please present your insurance card at the front desk along with a photo ID so that we can scan into our system and file a claim on your behalf. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.

2. All charges are your responsibility whether the insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what a covered benefit is and what is not. Please check your insurance plan document for any questions. Fees for these services along with unmet deductibles, co-insurance and co-payments are due at the time of treatment.

3. Co-Payments not paid at the time of service are subject to a $10 processing fee. There is a $35 NSF charge on all returned checks.

4. Surgery Deposits:. Due 5 days prior to surgical procedure. Self-pay patients – 50% of surgery deposit is due before we schedule surgery unless MD approves otherwise.

5. Balances older than 90 days may be subject to collection proceedings and collection fees which will be charged to the responsible party. If we are forced to send your account to a collection agency, a 40% fee will be added to your balance.

6. Please note that all cancellations for scheduled surgery appointments must be made at least 72 hours in advance, which allows our physicians to care for other patients in need of our services. If you fail to cancel your surgery, you may be charged a $100 service fee which will not be covered by your insurance plan. If you are undergoing surgery, it may be necessary, at the physician's discretion, to use an assistant surgeon or a licensed surgical assistant to safely complete your surgery. Any assistant surgeon fees not covered by your insurance will be the patient's responsibility. If you are undergoing surgery, please note that some of the physicians have a financial interest at these named facilities:
   Bailey Square Surgery Center: Robert Askew, Jr., M.D., Brant Victor, M.D.
   Central Park Surgery Center: John Abikhaled, M.D., Jeffrey Meynig, M.D.
   Medical Park Tower Surgery Center: Robert Askew, Jr., M.D., Mark Lindsey, M.D.

7. Occasionally an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visit. You may request a refund of overpayment by notifying the Office Manager or our Billing Service.

8. Patients without insurance coverage are eligible for a 40% discount off of our billed fees. However, to receive this discount, payment must be made in full at time of service.

9. We understand that temporary financial problems may affect timely payment on your account balance. We encourage you to communicate any such problems to our Office Manager or Billing Service, so that we can assist you in management of your account with an acceptable payment plan. You may request a copy of this billing policy, an itemized statement of your account for any service we provide at any time.

Again, thank you for choosing **Austin Surgeons, PLLC.** We appreciate the opportunity to serve you. Please sign below to acknowledge this financial policy and agree to adhere to it.

Print Name: _____ Signature: _____ Date: _____