Chart:
Date:

WILMINGTON SURGICAL ASSOCIATES, P.A.

Financial Policy

PAYMENT

We accept Cash, Check, Money Order, or Credit Card: Visa, MasterCard, Discover or American Express.

If you do not have heath insurance the entire amount due will be collected before your office visit. In the event of surgery the entire amount due will be collected prior to surgery.

If you have health insurance we require any co-pay, deductible or co-insurance to be paid before services are rendered. In the event surgery is scheduled, any co-pay, deductible, or co-insurance will be collected prior to surgery.

All patient balances are reviewed for collection after 30 days.

INSURANCE

A current valid insurance card is required in order to file a claim with your insurance company. Please bring your current insurance card with you for every visit to our practice.

Your insurance policy is a contract between you and your insurance company. Wilmington Surgical Associates, P.A. is not a party to this contract. Please be aware that some, or perhaps all, of the services we provide may not be covered.

Wilmington Surgical Associates, P.A. is a participating provider of most health plans. If Wilmington Surgical Associates is not a participating provider in your plan, it will be your decision to receive treatment outside of the provider network. In these cases, you will be responsible for payment.

ASSIGNMENT OF BENEFITS

I hereby assign to Wilmington Surgical Associates, P.A. any insurance or other third-party benefits available for health care services provided to me. I understand that Wilmington Surgical Associates, P.A. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Wilmington Surgical Associates, P.A., I agree to forward to Wilmington Surgical Associates, P.A. all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

GUARANTEE

I have read and understand this policy. I guarantee payment of any balance not covered by my insurance company and/or I guarantee payment if I do not have insurance coverage.

X _____ Date _____

Signature of Patient or Responsible Party

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