



* 724721w25176 Admin

BILLING AND FINANCIAL POLICY – pg. 1 of 2

The following sets forth the policies of BASS Medical Group. Please review this information and sign where indicated below.

- ❖ I understand that it is my responsibility to furnish BASS Medical Group with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$25.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.
- ❖ I understand that a cancellation fee of \$50.00 may be billed directly to myself if a 48 hour cancellation notice is not provided to our office. All cancellation fees must be cleared with our financial office prior to your next appointment.
- ❖ I understand that a surgery cancellation fee of \$250.00 may be billed directly to myself if a surgery is cancelled. This fee will also be assessed if cancellation has not been made 7 days prior to scheduled surgery date. This fee must be cleared with our financial office before surgery can be rescheduled.
- ❖ It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. BASS and/or its representatives will make every effort to assist you but BASS will not be held accountable for understanding every insurance plan.
- ❖ I understand that there is a \$15.00 fee (per form) to complete disability paperwork associated with my care.
- ❖ I understand that the clinic will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that a surgery co-pay may be collected upfront and applied to those fees. I further understand that ANY FEES I AM QUOTED ARE ESTIMATED based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.
- ❖ I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with at least 2 statements for any balance due after insurance payment. Payment in full is due within 30 days of your first statement unless other arrangements have been made. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be a final notice and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.
- ❖ I understand that the clinic will obtain the necessary authorizations prior to surgery. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.



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BILLING AND FINANCIAL POLICY - pg. 2 of 2

- ❖ I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of BASS Medical Group.

Legal Signature

Date

Print Patient's Name

Relationship to Patient