

SAVANNAH VASCULAR INSTITUTE

PHYSICIAN PRACTICE FINANCIAL POLICY AND RELEASE OF INFORMATION

The following statement of our Financial Policy for services provided within our office and do not apply to any testing or diagnostic procedure performed outside of this physician practice. We require you to read and sign this document prior to treatment at this facility.

PATIENT RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service. As a courtesy this practice will file your claim with your insurance carrier, however the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.

Initial _____

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is your (the patient) responsibility to understand your insurance coverage.

Initial _____

When you receive a statement from the Memorial Health Physician Practice, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you are to contact a billing representative at the phone number noted on the statement. Do not ignore the bill as it may result in turning the balance to an outside collection agency for recovery.

Initial _____

AUTHORIZATION FOR TREATMENT AND TO RELASE INFORMATION

The signature below serves as authorization for medical treatment by the physician, physician's assistant, Nurse Practitioner, or nurse for the named patient. It also provides authorization for this Memorial Health Physician Practice to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization also serves as permission to obtain a copy of your complete medical record from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining medical records. I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by a written withdrawal.

Initial_____

I understand that I am financially responsible to the Memorial Health Physician Practice for any balance not covered by my insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits to be paid directly to this Memorial Health Physician Practice.

Patient Name (Please print)

Signature of Patient or Responsible Party

Date