Performance Surgery Center

1084 Main Ave., 2ND FL
Phone:(973) 574-3520 ♦ Fax: (973) 473-2630

FINANCIAL AGREEMENT

Patient: _____

The fee for surgery is determined by many factors, including the type and complexity of the procedure being performed. Although many insurance companies accept our facility fees as appropriate, we cannot guarantee that your specific insurance policy will consider our fee as "usual, customary or reasonable." In general, our billing department will submit a bill for surgical services rendered within three weeks of your procedure to your insurance carrier. Once your insurance carrier sends us their payment determination, you will be billed for the balance of our "reasonable and customary" fee. Assuming a generally-accepted benchmark, if you have a 90% usual and customary policy with your insurance, your out-of-pocket cost will be 10% of our fee. With a 100% usual and customary major medical policy, a substantial portion – if not the entire surgical bill – will be covered.

By signing below, you hereby acknowledge that you have been informed of, and agree to, the following:

1. If the facility participates in my managed care plan, I will be responsible for payment of any fees as determined by the contract of the managed care plan;
2. I am responsible for any deductible, coinsurance, copayment or any other balance deemed the patient's responsibility per my insurance plan;
3. I must remit any insurance checks I receive from my insurance carrier to the facility's billing office within five days of receipt;
4. I am directly responsible for the payment of the facility's bill, regardless of third-party reimbursements;
5. I understand that the facility fee does not include any professional or anesthesia service fees and that anesthesiologists, medical and other consultants bill separately for their efforts on my behalf;
6. I am responsible to complete paperwork or obtain a referral or pre-authorization if required by my insurance carrier and will be responsible for payment of any medical services denied by my insurance carrier for failure to complete any such paperwork or obtain any such referral or pre-authorization;
7. I authorize payment of my medical benefits directly to PERFORMANCE SURGERY CENTER; and
8. For car accidents and job-related injuries, I understand that my insurance carrier will not pay my bills in full and that I am directly responsible for any outstanding balance that my accident insurance and private insurance do not pay.

_____ _____

Patient (or Responsible Party/Legal Guardian) Signature[1] Date

_____ _____

Print Name If Not Self, Relationship to Patient

[1] The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.