

Financial Policy

Thank you for choosing us as your health care provider. The physicians and staff are committed to your treatment being successful. Please understand that payment of you bill is considered part of your treatment. This statement of financial policy must be read and signed by you prior to any treatment. Furthermore, all patients must complete the patient information form before seeing the physician.

All co-pays, deductibles and co-insurance are due at the time services are rendered. We accept cash, checks, Visa or MasterCard.

Regarding Insurance:

The balance on your account is still your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 90 days from the date services are rendered, the balance will automatically be transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided by the physician, an audiologist, or other licensed professional may be non-covered services and not considered reasonable and necessary under your medical insurance.

It is your responsibility to inform us if your insurance or your Physician/Provider changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

I, \_\_\_\_\_, have read the above information and agree with  
Print your name here

the terms of the Financial Policy.

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Release of Medical Information:

This will serve as authorization to release all medical records contained in the medical chart that relates to any physical condition or treatment given by any physician employed by Surgical Specialists of Oklahoma, P.C. to the above named patient. This will also serve as authorization for release of information to referring physicians and the patient's insurance company for insurance claim purposes.

The information authorized for release may include records which may indicate the presence of a communicable or verbal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhoea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). Oklahoma Statute: 63OS 1.502.2

I also authorize you to accept a photocopy of this release and it shall have the same force and effect as if it were the original.

I acknowledge that I understand all of the above information. My signature indicates that I have read this Medical Release and grant the request for Authorization.

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICARE PATIENTS ONLY

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my medical treatment.

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_