Select Surgical Center 405 Hurffville-Crosskeys
Road Suite 210
Sewell, NJ 08080

Statement of Financial Responsibility

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of Select Surgical Center of any insurance benefits otherwise payable to me or on my behalf for the procedure(s) performed at Select Surgical Center, at a rate not to exceed Select Surgical Center's regular charges. This Assignment of Benefits is valid for all insurance companies and programs including Medicare.
AUTHORIZATION FOR

RELEASE OF INFORMATION

I authorize Select Surgical Center to release medical information concerning the procedure(s) performed at Select Surgical Center as may be requested by third party payers in order to process payment of claims. I also authorize Select Surgical Center to release information (including information regarding communicable or venereal diseases) to my insurance company, peer review or hospital if transferred for follow-up care.

OUT OF NETWORK INSURANCE PATIENTS

Select Surgical Center has agreed to accept the amount or percentage that your insurance carrier has agreed to pay for your surgical procedure(s). This amount does not include any necessary co—payment, which remains **your responsibility for payment on the day of surgery.** You will be held responsible for the full charge if your insurance denies for pre-existing conditions, non-compliance with information requested by your carrier, or for workers compensation or motor vehicle charges should your claim be denied or unrelated. Please be aware if we are NON-PARTICIPATING with your insurance carrier, you may receive the reimbursement check for the facility's fees. **DO NOT DEPOSIT THE CHECK**. You must endorse the check and forward it with the accompanying explanation of benefits form to the center at the above address. Your insurance carrier will inform the center that this has occurred. If you do not turn over the check and explanation of benefits, you will be responsible for the entire bill.

MEDICARE PATIENTS

Select Surgical Center is a participant in the Medicare insurance program. We accept assignment for your facility fee. To comply with Medicare regulations, you are responsible for payment of your yearly unsatisfied deductible and any applicable coinsurance amounts at the time of procedure. If you have secondary insurance coverage, we will bill that carrier for the balance.

CREDIT POLICY

In the event that this account is placed with a collection agency, I agree to be responsible for the collection fees, reasonable attorney's fees and court costs. I HAVE READ AND UNDERSTAND THE TERMS OF THIS POLICY STATEMENT. I also understand that it is my responsibility to be knowledgeable regarding my insurance coverage and for providing accurate insurance information.

_____ _____

Patient Signature (parent or guardian, if minor) Date

_____ _____

Witness Date