Associates in General Surgery, A MEDICAL CORPORATION

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STATEMENT OF FINANCIAL RESPONSIBILITY
ADVANCE BENEFICIARY NOTIFICATION

Dearest Patient:

It is our honor and privilege to participate in your medical care. We will do our best to provide excellent care for you. We will provide coverage 24 hours per day, seven days a week. If you have any problems or questions we are here for you.

You may have insurance and we will be happy to bill your insurance for you. On occasion your insurance may not pay our charges. Some reasons may be pre-existing medical conditions, the service performed may be excluded from coverage, you may not be eligible for coverage when the service is actually performed or there may be a change in your insurance coverage. In the event your insurance does not cover our charges, you are still responsible for payment to your doctor and this office.

Associates in General Surgery and Affiliated Providers

_____ I understand that my insurance may not pay the charges for your services and that you may bill me, and I may have to pay the bill in advance, or while my insurance is making it's decision. If my insurance denies payment, I agree to be personally and fully responsible for payment. If my insurance does pay, you will refund to me any payments I made to you, less co-payments and deductibles.

_____ I have decided not to receive services from you. I understand that you will not submit a claim to my insurance for services not rendered.

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Signature of patient or person acting on patient behalf **Date**

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