South Seminole Surgical Group
521 West SR 434 Ste. 301, Longwood, Fl 32750
Ph. 407-767-5808 Fax. 407-767-5892

FINANCIAL POLICY DISCLOSURE STATEMENT

Thank you for choosing South Seminole Surgical Group as your healthcare provider. Because of the many changes with insurance companies and the requirements of referrals/authorizations by primary care physicians, we are requesting that our patients sign this **Financial Policy Disclosure Statement** stating that you are aware that you will be personally financially responsible to pay for any service which your insurance company declines to cover.

We will file your insurance claims as a courtesy. If your claims have not been paid within a timely manner you may receive a billing statement notifying you of these circumstances. However, you will be responsible for any deductibles and/or "non-covered" services denied by your insurance plan for any reason; including but not limited to, denials of coverage and/or any payments made directly to you.

All self-pay and non-participating insurance patients will be expected to have payment in full at the time of their visit. Any and all past due patient balances will be collected at the time of your appointment. If your insurance requires a co-pay and/or deductible, this will be collected at the time of your appointment.

This financial policy statement must be signed prior to treatment. I hereby individual obligate myself to pay and unconditionally guarantee payment to the provider(s) of service. I hereby certify that I have read and understood the FINANCIAL POLICY agreement.

_____ _____
Signature of patient, parent, or legal guardian Date

_____ _____
Printed Name of patient, parent, or legal guardian Witness

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicaid/Other Insurance Company benefits, be made either to me or on my behalf to Orlando Regional Healthcare for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicaid assignments of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicaid claim/Other Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for payment my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

_____ _____
Signature of patient, parent, or legal guardian Date

_____ _____
Printed Name of patient, parent, or legal guardian Witness