Acknowledgement of Financial Responsibility

Patient Name: _____ Date of Service: _____

Thank you for choosing Northpointe Surgical Suites as your preferred choice for surgical care. Our goal is to provide complete patient satisfaction, which includes informing you of our financial policies, your financial obligation, and what to expect after your procedure. We ask that you carefully review the below information and keep the copy provided for reference in the future. Please contact our office at any time throughout the billing process with questions or concerns.

You have indicated that you are covered by: _____

The surgery center verifies insurance benefits and eligibility, however exact coverage and benefits cannot be determined until the claim is processed by the insurance carrier. As a courtesy to our patients, we will file medical claims with your insurance company. Final patient responsibility is determined based on the allowed amount of the claim as listed on the insurance company Explanation of Benefits, and the patient's applicable benefit levels. When patients receive payment directly from the health plan, patients must endorse and forward the payment and Explanation of benefits to the surgery center within 5 days of receipt to avoid additional financial liability.

Once your statement is received, please contact our staff if you are experiencing a financial hardship, are in need of alternative payment arrangements.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility, and agree to abide by the terms of the surgery center financial policies as stated in the Authorizations & Disclosures and Billing Policies made available to me.

_____
Name of Patient

_____ _____
Signature of Patient / Authorized Representative & Financial Responsibility Party — Relationship — Date

_____ _____
Witness — Date