Indio Surgery Center
Financial Policy

FINANCIAL POLICY

CASH PATIENTS
Full payments is due at time of service. We accept CASH, VISA, and MASTERCARD
Payment plans and financing options may be available: please inquire

PRIVATE INSURANCE CARRIERS
When we are provided with insurance information, we will bill your insurance company. Deductibles and co-payments are due at time of your visit. Any co-insurance obligations you may have, as determined by your insurance provider, will be estimated by Indio Surgery Center and located at time of service.

MEDICARE AND WORKER'S COMPENSATION
If you are covered by Medicare, Denti-Cal/Medi-Cal or Workers Compensation, we require that you have proof of such coverage for billing purposes.

GENERAL INFORMATION
Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. Your insurance claim is filed as a courtesy to you. We will generally submit one bill each for dental, general anesthesia, and facility fees. Please note that our surgery center is an 'out of network' provider. We will not become involved in disputes between you and your insurance carrier regarding deductable, co-payments, etc., other than to supply factual information as necessary. In the event that your insurance company denies any dental or medical services performed, you hereby authorize Indio Surgery Center to file an appeal on your behalf. Should your insurance carrier deny the claim thereafter, you will be responsible for all surgical centers fees. Should your insurance pay after denying any part of a claim, these funds must be paid over to the Indio Surgery Center by you, even if Indio Surgery Center has arranged a discount of financing plan. You are responsible for the timely payment of your account. Should your account become past due, you will be responsible for any finance charge or legal fees necessary to collect in this account.

FINANCIAL CONSENTS

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES
I hereby authorize Indio Surgery Center and its affiliates to release any information in the course of my examination and/or treatment to my insurance company (ies) for the purpose of billing. I also authorize the release of information to my employer if my examination and or treatment is/are work related.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
I hereby authorize the dental, medical, and/or surgical benefit payments to be made directly to Indio Surgery Center and/or its affiliates. It is understood that benefits are not to exceed the reasonable and customary charge for these services and any moneys received from the insurance company over and above any indebtedness (should this be above any deductable or prepayment) will be refunded to me when my bill is paid in full. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY(IES) AND THIS AUTHORIZATION, AND THAT THIS DOCUMENT CONSTITUTES THE ENTIRETY OF ANY FINANCIAL AGREEMENT.

PATIENT ACKNOWLEDGEMENT OF PHYSICIAN DISCLOSURE OF OWNERSHIP INTEREST

This is to advise you that doctors may have ownership interests in this surgery center. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than this one.

As the patient or responsible party, I hereby consent to receiving auto-dialed and/or artificial or pre-recorded collection or health-care related message calls and text messages to my cellular phone number and any other telephone numbers provided during any interaction, agreement or communication with the facility, its independent contractors, and/or their affiliates, agents and contractors, including any of their billing or account management companies and/or debt collectors."

Please let us know if you have any questions or concerns.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OF THIS POLICY AND THE ABOVE PARAGRAGHS.

PARENT OR GUARDIAN: ________________________________ PATIENT NAME ___________________________

SIGNATURE ____DATE __________________________