

# Patient Financial Policy for ANESTHESIA SERVICES at Geneva Woods Surgical Center by DENALI ANESTHESIA, LLC

Thank you for the opportunity to serve you at the Geneva Woods Surgical Center. We are committed to providing you with safe, high quality anesthesia care at this medical facility.

**Fees for Anesthesia services are separate from the facility fee, and separate from the surgeon's fee.** Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify us of any patient information changes (i.e. address, name, insurance information, etc). Call us at (833) 679-0182

## **Self Pay – No Insurance**

A 20% cash discount is offered to patients with no insurance if paid in full within 15 days of the procedure. You may obtain an estimate of anesthesia fees when you schedule surgery. Since anesthesia fees are based on time, we cannot give you an exact quote prior to surgery. You will be sent a statement for the balance. Payment options include check, cash, VISA/MC/Discover. **Cosmetic Procedures** All anesthesia fees related to cosmetic procedures require advance payment. Self Pay Discount does not apply to cosmetic procedures.

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for our services, you may be responsible for the complete balance. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

## **Workers' Compensation and Automobile Accidents**

In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier 48 hrs prior to surgery. If this information is not provided, you may be asked to either reschedule or pay in full yourself. We do not bill third party auto insurance. We will only bill your own auto policy and only if there are benefits available to do so. Questions: (833) 679-0182

## **Returned Checks**

The fee for a returned check is \$30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. Your account may be flagged as 'cash only' following any returned check.

## **Minors**

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

## **Outstanding Balance Policy**

It is our office policy that all accounts be sent two statements. Prompt payment is appreciated. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to a collection agency.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our facility, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party. I understand that Denali Anesthesia, LLC will not release my medical information to anyone other than my insurance carriers unless I specify otherwise. I authorize the release of my medical and/or billing information to the following individual: \_\_\_\_\_ . Relationship: \_\_\_\_\_

I, \_\_\_\_\_ have read the above financial policy and understand my financial responsibility for anesthesia services, and agree to these terms.

Patient / Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

CALL (833) 679-0182

FOR ANY BILLING QUESTIONS OR TO OBTAIN ANESTHESIA FEE ESTIMATE OR SELF PAY DISCOUNT