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PATIENT:

SURGEON:

FINANCIAL POLICY

Thank you for choosing Cornerstone Surgery Center as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance Form before surgery.

We accept Cash, Check, or Credit Cards (Visa, MasterCard, and Discover).

We require the estimated percentage of your insurance co-pay before your surgery. We have estimated to the best of our ability what the insurance company will pay for your procedure; however this may be more or less than the amount actually received. The balance is your responsibility whether your insurance company pays or not. If an overpayment is received, this amount will be refunded to you in a timely manner. We cannot bill your insurance company unless you give us your correct information and consent. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you're insurance company has not paid your account in full within 45 days, that balance will be automatically transferred to the patients' responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and /or other insurance.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**CORNERSTONE SURGERY CENTER IS A SEPARATE ENTITY
FROM METROCREST ORTHOPAEDICS AND SPORTS MEDICINE,
AND PINNACLE ANESTHESIA.**

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ Date: X _____
Signature of Patient/Responsible Party