URGENT SURGERY ASSOCIATES, P.A.

INSURANCE INFORMATION

Name of Insurance Company: _____

Subscriber Name: _____ Policy #: _____

Group #: _____ Individual #: _____

Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Our professional fees have been determined through careful consideration and are reasonable and customary within our geographical area. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy. A copy of our Financial Responsibility Notice is available for your review.

FINANCIAL AGREEMENT

- Please remember that your insurance coverage and benefits are a contract between you and your insurance company. We are happy to assist you in identifying coverage for services. If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a self-pay patient and will be responsible for payment at the time services are rendered. Claims will be filed on your behalf as "out of network".

I agree to pay for services rendered. If applicable, I agree to pay for my co-payment or co-insurance at the time of service and I understand that I will be fully responsible for any services deemed as non-covered or denied by the insurance company. I also understand that there may be a patient responsibility balance even after the payment of my co-pay or co-insurance, once the claim is processed.

I understand that I am personally financially responsible to Urgent Surgery Associates, P.A. (URSA) for any charges not covered by an insurance plan. I understand that URSA is not contracted with most insurance companies and I may be billed for any non-covered charges.

I understand that payment to URSA can be made in the form of cash, check or credit card. There will be a $25 per check charge for all returned checks as having non-sufficient funds. I agree to pay any necessary fees if my account becomes delinquent and is turned over to a collection agency. If payment in full is not possible at time of service, payment arrangements may be discussed.

I hereby authorize URSA to release all medical information necessary to process claims. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Urgent Surgery Associates, P.A. any and all plan documents, insurance policy and/or settlement information upon written request from URSA in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby assign all medical and surgical benefits and hereby authorize and direct my insurance carrier(s) including Medicare, Medicaid, private or commercial insurance and any other medical/health plan, to issue payment directly to Urgent Surgery Associates for medical services provided to myself and/or dependents regardless of my insurance benefits.

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Signature of Insured/Guardian Date