C E N T R A L   J E R S E Y S U R G I C A L S P E C I A L I S T S

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Clinical Assistant Professor of Surgery

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Board Certified in Vascular & General Surgery

219th President of Medical Society of New Jersey (2011-2012)

AUTHORIZATION FOR PAYMENT

I hereby agree that I am financially responsible to Central Jersey Surgical Specialists for all co-pays, coinsurances, deductibles and fees for non-covered services that are rendered to me. To the best of my knowledge, I have furnished CJSS all accurate information regarding my health insurance. If any inaccuracies should occur, which result in non-payment, I will be responsible for full payment of all services rendered. I agree for authorization for credit card or bank debit payment by phone.

Many of the insurance organizations require appropriate ***REFERRAL*** documents from the Primary Care Physician. You must come to the office with these REFERRALS; Please do not rely on your Primary Care Physician office to fax documents to us. This referral is your responsibility.

If you are *scheduled* for *SURGERY*, please check with your insurance plan for any special requirements regarding pre-certification of surgical procedures and/or policy exclusions. We will bill your insurance company for your surgical charges. In many cases, insurance payments are reimbursed directly to our office. However, if the insurance company reimburses you directly please forward the payment with a copy of the "Explanation of Benefits" to our office. We will bill 2ndary insurance payers on behalf of the patient upon receipts of the "Explanation of Benefits" and primary insurance payment.

If you are *scheduled* for SURGERY and your insurance carrier requires you to pay **DEDUCTIBLE** and **Co-Insurance**, we require a **FULL PAYMENT** of our surgical fee the day prior to procedure date. If for any reason we receive payment from insurance, we will refund the amount overpaid. **No installment payment will be allowed.**

IF NO PAYMENT IS MADE, and the bill goes to collection, you agree to reimburse us the fees of any collection agency, which may be used on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorney's fee, we incur in such collection efforts.

____________________________________ ____________________

Signature of patient or Guardian **Date**

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