Aswad Surgical Group

Assignment of Benefits/Financial Policy

I hereby assign to Aswad Surgical Group any insurance or other third-party benefits available for health care services provided to me. I understand that Aswad Surgical Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Aswad Surgical Group, I agree to forward to Aswad Surgical Group all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I understand that **all** copays and deductibles are my responsibility and will be billed to me by your office. If it is determined that I am not eligible for coverage by my insurance company, **I understand that I will be responsible for payment on all services provided**.

All outstanding balances are due within 30 days from the date of service unless prior arrangements have been made with the Billing Department. All balances that reach 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the practices "Notice of Privacy Practices".
I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person listed. I, furthermore, understand that Aswad Surgical Group will offer me updates to the "Notice of Privacy Practices" should it be updated or changed in any way.

I have read and fully understand the Financial Policy, Assignment of Benefits, and Acknowledgement of Notice of Privacy Practices set forth by ASG and I agree to the terms of these policies. I also understand and agree that the terms of these policies may be amended by the practice at any time without prior notification to the patient.

_____ _____

(Please Print) Patient or Representative Name Relationship to Patient

_____ _____

Patient or Representative Signature Date

Other people who may access your health records: _____

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