Patient Sticker Here

Date of Procedure:_____

RIVER VALLEY
45 Salem Turnpike, Norwich, CT 06360

FINANCIAL AGREEMENT

FINANCIAL AGREEMENT: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the Center may disclose portions of my financial and/or medical records to any person or entity who may be liable for all to any portion of the Center's chargers, including but not limited to insurance companies, health care service plans, or worker's compensation carrier(s) as well as to those individuals the Governing Body may deem appropriate to review the medical record for purpose of medical quality assurance/improvement and peer review. Whether signing as the patient of his/her agent, in consideration of the services rendered, patients/guarantors shall be individually responsible to pay the Center for all such services, at the Center's regular rates and terms, should the insurance company deny payment. Patients/guardians shall also be responsible for any deductible or co-pay owed at the time of service. Should this account be referred for collection to any attorney or collection agency, patients/guardians shall pay all attorney's fees and collection expenses in connection therewith, if the patient's account is delinquent. Patients/guardians shall be responsible for paying the Center interest on the full outstanding balance at the maximum rate allowed by law.

ESTIMATE: The Center strives to provide patients with an accurate estimate based on a patient's insurance benefits. This is strictly an estimate. Variances in fees and financial liability may occur after claims are processed by the insurance. Patients/guardians shall be responsible for paying all financial responsibility determined by the insurance.

FACILITY FEE: The physicians, including anesthesiologists, treating patients at the Center will bill and collect for their professional services separate from the Center's billing and collection of a facility fee. Bills may also be submitted by pathology, implant vendors and other relates services as applicable. The facility fee covers the costs of the use of the Center, its staff, equipment, supplies and related expenses connected with the case. Because each component is billed separately, it may result in patient liability for each individual entity.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY – By signing below, the patient/responsible adult hereby agrees to irrevocably assign all medical and/or surgical benefits, to include major medical benefits to which the patients are entitled, including Medicare, Medicaid, Champus and all other government sponsored programs, private insurance and any other health plans to River Valley ASC, LLC (Center) and all their providers including but not limited to laboratories, and clinical care workers. The patient/responsible adult understands that he/she may cancel in writing at any time this request for payment to the Center. Medicare will only pay for services that are determined to be "Reasonable and Necessary" under section 1882(a) of Medicare law. Furthermore, the patient/responsible adult understands that he/she is financially responsible for all services rendered.

NOTE: Please read the above agreement carefully and make sure that you understand all terms and conditions before signing below. ***If you do not understand, please review contents with staff prior to signing.***

_____ _____
Patient/Responsible Adult Signature Date

_____ _____
Patient/Responsible Adult – Print Name Relationship to patient (if signed by person other than patient)

_____ _____
Interpreter (If required) Signature Date

Fill out this section ONLY if you *accept financial responsibility for the patient for who you have NO legal responsibility.* I, the undersigned person, hereby certify that I have accepted *total financial responsibility* for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: laboratories, and clinical care workers. I understand that I do not currently do not have any legal responsibility to proved financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatment/services provided to the patient by the Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. ***Please fill in all sections below and sign where indicated.***

Name: Last_____ First_____ Middle Initial ___ Social Security Number_____-_____-_____

Relationship to patient:_____ Home phone number (_____)_____ Date of Birth _____

Address: _____ City:_____ State: _____ Zip code:_____

Driver's License OR Other photo ID #:_____ Type of ID:_____ State Issued:_____

Occupation:_____ Employer:_____ Business Phone Number(____)_____

Signature of Responsible Party:_____ Date:_____

Interpreter (if required): Print name:_____ Signature:_____ Date:_____