Fall General Surgery, LLC
Financial Policy and Authorization to Bill and Release Medical Records

Welcome to Fall General Surgery. We have made it our mission to consistently provide outstanding patient care. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our billing coordinator at (715) 685-0656.
Your clear understanding of our **FINANCIAL POLICY** is important to our professional relationship.

- WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY; HOWERVER, WE MUST HAVE A CURRENT COPY OF YOUR INSURANCE CARD.
- WE ASK FOR A COPY OF YOUR ID OR DRIVER'S LICENSE DUE TO THE MANY CASES OF IDENTITY THEFT.
- WE ACCEPT CASH, CHECK, VISA/MASTERCARD, DISCOVER, CARE CREDIT, AMERICAN EXPRESS AND HEALTH SAVINGS ACCTS.
- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" AND OTHER RELATED FORMS.
- PLEASE NOTIFY US **IMMEDIATELY** OF ANY CHANGES IN YOUR INSURANCE COVERAGE.
- 5 BUSINESS DAYS NOTICE IS REQURED FOR COPIES OF MEDICAL RECORDS. THERE MAY BE A NOMINAL FEE FOR THIS SERVICE.

INSURANCE COVERAGE: All co-payments and estimated of out-of-pocket expenses are your responsibility. If you are unable to pay this estimate, we may ask you to reschedule your appointment. We are members of most, but not all plans. You are responsible for verifying that Fall General Surgery is an in-network provider for your plan. We encourage you to refer to your benefits manual if you have any questions about covered services. **Be aware that some and perhaps all of the services provided may be not covered by your insurance. You will be responsible for payment of all non-covered services.**

PATIENT PAYMENTS: It is the responsibility of the patient to pay his/her co-payment, deductible and any unpaid portion of the bill. You may use cash, check, credit/debit card, Care Credit or a health savings account to pay your balance. For those with a high deductible policy, our Patient Accounts Manager can discuss with you a good-faith estimate of your out-of-pocket expenses. Patients without insurance must pay in full prior to services being rendered. Patients should consult with our Patient Accounts Manager for payment options.

LATE OR NO PAYMENT ON ACCOUNT: Any patient that does not pay their agreed payment, or is late with their payment, will be assessed an 18% annual fee that will be added to the billing cycle from first date of service.

"NO SHOW" APPOINTMENTS: Any patient who calls our office after their missed appointment, or simply does not show up, will be considered a "no show". Three or more "no shows" will result in dismissal from the clinic.

RETURNED CHECKS: There is a $35.00 fee for all returned checks.

AUTHORIZATION TO PAY AND RELEASE MEDICAL RECORDS: Our office will bill your insurance. If you do not have insurance, we require payment at the time of your visit. Our staff is available if you have any questions or concerns. Fall General Surgery LLC reserves the right to withhold overpayment refunds less than or equal to $5.00.

I authorize payment of medical benefits be made directly to Fall General Surgery, LLC for services rendered. I authorize release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize use of information from this form to bill my insurance companies.

I have read, understand, and agree to abide by the terms as of the Financial Policy and Authorization to Release Medical Records.

Patient's Signature: _____ Date: _____

Fall General Surgery, LLC

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and:

- I hereby assign and convey directly to Dr. George A Fall and NP Kelli Culver all medical benefits and/or insurance reimbursement, if any.
- I hereby authorize the doctors to release all medical information necessary to process this claim.
- I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctors and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctors and clinic 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 convey to the above-named providers to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above-named doctors and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Employee Retirement Income Security Act (ERISA) Eligible Patients Only *(Most Commercial Ins.)*:

I hereby convey Fall General Surgery (Authorized Representative) to the full extent permissible under the law, including but not limited to, any ERISA claim for benefits, breach of ERISA fiduciary duty, and ERISA claim for statutory penalties for failure to produce documents or information in accordance with ERISA §502(a)(1)(B), §502(a)(3) and §502(c)(1)(B), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received or was prescribed, and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies including, but not limited to, (1) obtaining information about the claim to the same extent as the beneficiary; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by Fall General Surgery to pursue such claim, chose in action or right against any liable party, party-in-interest, or employee group health plan(s), including, if necessary, funding and authority to bring suit by Fall General Surgery against any such liable party, party-in-interest, or ERISA employee group health plan, in my name.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctors and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctors and clinic against such insurers and/or employee health care plan in my name but at such doctors and lab's expenses. This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient's Signature: _____ Date Appointed: _____

(Continued on back side)