Please <u>read, sign and mail this sheet, along with your pre-registration form</u> prior to your date of surgery. Please also bring a picture I.D. and all of your insurance cards. Thank You!

St. Cloud Center for Ophthalmic Surgery
2055 North 15th Street, Suite B
St. Cloud, MN 56303
(320 251-1432 Fax (320) 251-7122

CREDIT & PAYMENT POLICY

There are a number of separate charges associated with your surgical procedure. You MAY receive charges from several companies.

1. *St. Cloud Center for Ophthalmic Surgery* for your operating room/recovery room facilities.
2. *St. Cloud Center for Ophthalmic Surgery CRNA* for the services of a certified registered nurse anesthetist.
3. *Your surgeon's office* – his/her fee for performing your surgery.
4. *Your pathologist* – services for tissue specimens removed during surgery requiring further examination.

**** We request that a prepayment on your deductible / co-insurance / copay amount due be paid on or before your date of surgery. You may also be asked to sign a financial agreement with us on your balance due.**

Full payment is due within 90 days from your date of service. Please contact your insurance company directly if you experience any delays. **YOU** are responsible for guaranteeing payment on your account and being aware of your individual policy restrictions and benefits.

Your insurance company, including Worker's Compensation, auto (no fault) and personal injury, is legally responsible to you. Our relationship is with you, our patient, not your insurance company. Consequently, all charges incurred are your responsibility. The obligation to assure payment in a timely manner lies with you regardless of what your insurance company chooses to do. You should normally receive a response from your insurance company within 30 days of your date of service. If you experience a delay, it is expected that you contact your insurance company to check the status of your claim and to expedite payment. Please call our **Business Office at (320) 251-1432** if you encounter a problem with your insurance company and need our assistance.

St. Cloud Center for Ophthalmic Surgery's policy is to turn over to an attorney or collection agency which are over 90 days old.

I hereby assign and transfer any benefits due me under my insurance company contract as follows insofar as they are necessary to cover the expense. A photostatic copy of this assignment shall be as valid as the original.

I authorize the physicians or facility to release any information required in the course of my examination or treatment at the St. Cloud Center for Ophthalmic Surgery to my insurance company if so requested by them.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

_____ _____

SIGNATURE DATE

<u>BILLING / COLLECTIONS</u>

THE ST. CLOUD CENTER FOR OPHTHALMIC SURGERY WILL BILL AS FOLLOWS:

<u>BLUE CROSS BLUE SHIELD OF MINNESOTA (BC/BS)</u>
We will submit your bill directly to Blue Cross & Blue Shield of MN. A bill will be sent to your secondary insurance upon receipt of payment or denial from BC/BS. If you have no secondary insurance, a bill will be sent to you for any balance after receipt of payment or denial from BC/BS. We must make a copy of each card at the time of registration.

AUTO INSURANCE / WORKER'S COMPENSATION
We will submit your bill directly to your auto insurance / employer / work comp insurance if your procedure is the result of an accident. We must make a copy of your insurance card, be provided with your claim number, date of accident, and insurance claim address at the time of registration.

HEALTH PARTNERS
We will submit your bill directly to Health Partners deductible / copay amount is due on or before your date of service. A bill will be sent to your secondary insurance upon receipt of payment or denial from Health Partners. If you have no secondary insurance, a bill will be sent to you for any balance after receipt of payment or denial from health Partners. We must make a copy of each insurance card at the time of registration.

MEDICA
Your Medica deductible / copay amount is due on or before your date of service. We will submit your bill directly to Medica. A bill will be sent to your secondary insurance upon receipt of payment or denial from Medica. If you have no secondary insurance, a bill will be sent to you for any balance after receipt of payment or denial from Medica. We must make a copy of each insurance card at the time of registration.

MEDICAL ASSISTANCE AND MINNESOTACARE
We will submit your bill directly to Medical Assistance. We must make a copy of your current MA or Minnesota-Care card at the time of registration.

PREFERRED ONE
Your Preferred One deductible / copay amount is due on or before your date of service. We will submit your bill directly to Preferred One. A bill will be sent to your secondary insurance upon receipt of payment or denial from Preferred One. If you have no secondary insurance, a bill will be sent to you for any balance after receipt of payment or denial from Preferred One. We must make a copy of each insurance card at the time of registration.

PRIVATE INSURANCE
Your deductible / copay amount is due on or before your date of service. We will submit your bill directly to your private insurance company. A bill will be sent to your secondary insurance upon receipt of payment or denial from your primary insurance. If you have no secondary insurance, a bill will be sent to you for any balance after receipt of payment or denial from your insurance company. We must make a copy of each insurance card at the time of registration.

SELECT CARE
Your Select Care deductible / copay amount is due on or before your date of service. We will submit your bill directly to Select Care. A bill will be sent to your secondary insurance upon receipt of payment or denial from Select Care. If you have no secondary insurance, a bill will be sent to you for any balance after receipt of payment or denial from Select Care. We must make a copy of each insurance card at the time of registration.

SELF PAY
You will be contacted prior to your surgery with an estimated procedure cost for your surgery. A down payment equal to 1/3 of the total estimated amount due is expected. You will be asked to complete a financial agreement. The remaining balance will be due within 90 days from your date of service.

SELF PAY – COSMETIC SURGERY – ELECTIVE SURGERY
Payment in full must be received 10 days prior to surgery.

NOTICE TO PATIENTS

Minnesota Statutes 144.652 (1974) requires all health facilities which are licensed under the provisions to sections 144.50 to 144.58, or 144a.02 to post a notice of "Patient's Bill of Rights" in a prominent place in the facility. This notice is posted in the waiting room.

If you have any complaints which arise out of these rights, the St. Cloud Center for Ophthalmic Surgery maintains a grievance mechanism to resolve them. If you have a complaint you may request a written response. The individual to whom you should address a grievance is:

Center Administrator
St. Cloud Center for Ophthalmic Surgery
2055 North 15th Street, Suite B
St. Cloud, MN 56303
(320) 251-1432

If you wish to direct a complaint to the Minnesota Department of Health, the address is:

Office of Facility Complaints
Minnesota Department of Health
393 Dunlap Street
PO Box 64970
St. Paul, MN 55164-0970
(612) 643-2520