Patient Name: ___________________________

Barrington Surgeons, Ltd.
Patient Financial Agreement

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to your professional relationship with Barrington Surgeons, Ltd.

We accept cash, checks, Visa, MasterCard and Discover.

The Patient Information Form must be filled out entirely and all insurance information provided before seeing the physician.

No Insurance: Payment in full at time of service.

HMO/PPO Insurance Plans: **All co-payments are to be made prior to seeing the doctor.** If you are unable to pay your co-pay at this time, your appointment may need to be rescheduled. All HMO patients are responsible for obtaining their referrals. If you require a referral and do not have one at time of service, our usual and customary fees must be paid at time of service.

Medicare: Barrington Surgeons, Ltd. accepts Medicare assignment. Please present your card at time of registration. We will be happy to bill any secondary insurance to Medicare if the insurance information is provided at time of service.

Auto Accident & Workers' Compensation: All information pertaining to accidental claims must be provided before services are rendered. In the case of workers' compensation, authorization to treat must be obtained prior to seeing the doctor.

Elective Surgery/No Insurance: A 50% scheduling deposit is required for all elective surgical procedures one week prior to surgery. Payment plan arrangements for any unpaid balance can be made with the Practice Manager.

NO-SHOW/MISSED APPOINTMENTS: Failure to notify our office within 24 hours of appointment may result in a cancellation fee of $25.

Administrative Forms: All forms will be completed in a timely fashion. There is no charge for a first time disability form/supplemental insurance form during a postoperative period. If additional forms need to be completed, there will be a charge of $10 per form. Your payment must accompany the form. All non-surgical patients requesting this service will be charged $10 per form.

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I understand that I am responsible for payment of my bills at the time of service unless I have made previous arrangements with the Practice Manager or have provided information required to process my claim through my managed care plan. I further understand that I will be responsible for any charges incurred in the collection of my account should it become necessary to refer my bill to a collection agency. I understand that I am financially responsible for any balance not covered by my insurance. This authorization is valid for 12 months from the date signed.

______________________________ ____________________

Patient or Responsible Party Signature Date