General Surgical Care, PC
5325 Northgate Drive, Ste. 204
Bethlehem, PA 18017

FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ **DOB:** _____

Subscriber: _____ **DOB:** _____ **Relationship to Patient:** _____

AS A MEDICAL PROVIDER, OUR RELATIONSHIP IS WITH YOU AND NOT YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO KNOW YOUR POLICY. WE CAN ONLY TELL YOU OUR CHARGE, AMOUNT PAID, AND AMOUNT OWED.

INSURANCE COVERAGE

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations. This information is furnished by the insurance carrier.
- If there are any unresolved insurance issues, your procedure may need to be postponed or rescheduled.
- If your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours.
- If you have any changes in your insurance coverage, you must notify us.

DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE & NON-COVERED SERVICES

- **Deductibles** are the patient's responsibility. The deductible is determined by the contract you have with your insurance carrier.
- **Co-payments, co-insurance and referrals** are the patient's responsibility.
- All patients are responsible for **"non-covered"** services.

INSURANCE PAYMENTS SENT TO YOU

- If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of benefits (EOB) received.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

Signature: _____ **Date:** _____