University SurgiCenter
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Notice and Acknowledgment Concerning Patient In-Network Payment Responsibility

[ ] Cigna [ ] United/Oxford [ ] Aetna [ ] QualCare [ ] Horizon

Dear Patient / Guardian,

You are scheduled to have a procedure on _____ and University SurgiCenter (the "Center") is a participating provider with your health benefit plan. This form describes your obligation to pay copayment, coinsurance and deductible amounts to the Center. Please read it carefully and sign it below.

You are expected to pay the copayment /co-insurance in full on the date of your procedure. Payment to the Center of the balance of the annual deductible under your plan is also expected on the date of your procedure if your annual deductible has not been already satisfied.

In the event your health benefit plan acts as secondary insurance, for example if Medicare is your primary, you will be billed separately for the co-insurance and deductible amount and you are responsible for payment in full within 30 DAYS of the invoice date. Additionally, if your deductible, copayment and or coinsurance was inadvertently not paid at time of your procedure, the Center will bill you the amount determined by your health benefit plan, and you are responsible for payment of the full invoiced amount within 30 DAYS of the date of the invoice or of the date you receive your insurance explanation of benefits.

You will be responsible for all charges related to claims that your health benefit plan determines retroactively to be medically unnecessary or not a covered service.

In order too, ensure payment by you of the full invoiced amounts, we require that you sign this letter below and return it to the Center before your procedure is performed, acknowledging that you agree to pay the following amounts if your payment is not received in full within 30 days of the date of invoice:

Thank You,

BUSINESS DEPARTMENT

Acknowledged and agreed to by: _____

Print Name: _____ Date: _____