

Parent/Guardian _____ DOB _____ SSN _____

Address _____

Phone No. _____

Employer _____

INSURANCE INFORMATION

Please provide receptionist copies of ALL current insurance cards.

GUARANTY OF ACCOUNT AND ASSIGNMENT OF BENEFITS

I understand that my insurance policy is a contract between me and my insurance company and that Seven Hills Surgical is not a party to that contract. I understand that some or perhaps all of the services provided may be part of my yearly deductible amount or co-payment responsibilities under my policy, non-covered services or deemed not necessary by my insurance policy. I understand that I am responsible for my bill regardless of any insurance company determination. I hereby assign my rights to payment of benefits to Seven Hills Surgical. Seven Hills Surgical agrees to file my insurance if I supply the accurate and necessary information.

I understand that Seven Hills Surgical requests that payment of any co-pays or deductible amounts be made at the time of service and that it accepts cash, checks, VISA and MasterCard. If I do not have insurance, I agree that my fees will be charged to either VISA or MasterCard or that I will complete an extended payment plan with Seven Hills Surgical.

In Medicare assigned cases, Seven Hills Surgical agrees to accept the charge determination of Medicare as the full charge. I am responsible only for the deductible, coinsurance and any non covered services. Coinsurance and deductibles are based upon the charge determination of Medicare. Seven Hills Surgical requests payment of deductible or non covered services at the time of service.

I understand that for minor patients, the adult accompanying and the parents (or guardians) are responsible for full payment. For non-accompanied minors, non emergency treatment cannot be performed unless pre-authorized satisfaction for charges is received.

I understand and agree that if my account is turned over for collection to an attorney, I will pay costs of collection, including thirty three and one third percent (33 1/3%) attorney's fees and court costs (including service of process costs) until my account is paid in full. I understand and agree that if any check presented as payment is subsequently returned by my bank for non-sufficient funds or any other reason, I will be responsible for any fees incurred by Seven Hills Surgical associated with such return.

I have read the above Guaranty of Account and Assignment of Benefits and understand and agree to the above terms.

CHARGE FOR COPIES OF MEDICAL RECORDS

I understand that if I request copies of all or any portion of my medical record be given to me, Seven Hills Surgical Associates will charge me for the provision of those copies at the rate of \$.50 per page for the first 50 pages copied and \$.25 cents per page thereafter in the case of copies generated from paper. In addition, I will be charged the actual cost of mailing those documents to me if I request that they be mailed. I hereby specifically agree to pay all such charges in advance in the event I request to receive copies of my medical records.

Signature _____ Date _____