**PATIENT FINIANCIAL AGREEMENT FORM**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Account#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The Physicians of Coastal Surgeons require this form to be signed by our Patients. We appreciate your cooperation. **If you have ANY questions, Please speak with Billing Department.** We are pleased to assist with your Insurance.

1. **FINANCIAL RESPONSIBILITY:** I understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with Coastal Surgeons.

I also understand that I will be responsible for any charge incurred by not providing the most current, and correct Insurance information to Coastal Surgeons. ***Exceptions to this policy are***: those patients with current authorization with HMO, a state or federally funded program, or a PPO in which Coastal Surgeons is currently contracted with.

**Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment for medical services provided directly to Coastal Surgeons Physicians.

**Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Coastal Surgeons will be responsible for billing and collection on Professional charges.** Coastal Surgeonsis not responsible for any bills you may receive from the hospital, including Anesthesia, Pathology or Laboratory services when surgery is performed. Please be aware that most surgery cases performed require an assistant to be present, not all assistants maybe contracted with your insurance policy. We will do our best to acquire a contacted assistant but this is solely based on availability of the assistant.

I understand and agree with the terms and conditions listed above.

**Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**