THE SURGICAL GROUP OF ORLANDO
1814 Lucerne Terrace
Orlando, FL 32806
Phone – (407) 730-3627
Fax – (407) 423-3817

FINANCIAL POLICY

Providing quality medical care for our patients is our primary concern. As a courtesy to all of our patients, we will bill all insurance for which information is provided whether we are a provider or not.

While we are pleased to be able to provide medical services to you, it is extremely difficult for us to keep track of all the individual requirements of the various insurance plans. Within the same insurance company, the plans differ, depending upon what type of contract your employer has negotiated. Each one has different policies regarding how often services may be rendered, and even more importantly, where those services may be performed.

We are enrolled in numerous insurance programs however; it is your responsibility as the patient, and as the insured, to obtain all authorizations and/or referrals from your primary care physician for all office visits, outpatient tests or referrals to other physicians. It is STRONGLY recommended that you contact your primary care physician personally to be sure that the proper authorizations have been processed PRIOR to all appointments or tests. In the event that you are scheduled for surgery, our office will contact your insurance company for you for authorization. Authorization is not a guarantee of payment from your insurance company.

If you do not have insurance or if we are not a provider for your insurance you will be responsible for services as they are rendered or the difference between what your insurance covers and the doctor's total charges.

You will be responsible for all co-pays and unmet deductibles at the time of your office visit. Elective surgery will require a deposit.

Our office utilizes a third-party collection agency for unpaid patient obligations. In the event that your account is transferred to this third-party agency all reasonable collection costs and/or attorney fees will become your responsibility.

This information is provided for your convenience, so that you will be aware of your financial responsibility for the medical care, which you have or are about to receive. With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED. I ALSO HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE SURGICAL GROUP OF ORLANDO. I AUTHORIZE THE SURGICAL GROUP OF ORLANDO TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM TO MY INSURANCE COMPANY.

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Signature Date