

**JOHN A. ZITELLI, M.D./DAVID G. BRODLAND, M.D.
FINANCIAL POLICY**

Thank you for choosing us. We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy. Please sign it prior to any treatment.

- Payment for non-covered or cosmetic procedure is due at the time of service.
- We accept cash, check, or credit cards.
- An 10% service charge will be added to bills over 30 days old.
- We offer an extended payment plan for patients meeting low income or financial hardship criteria.

PARTICIPATING PLANS:

We will be happy to bill insurance plans we participate in. Once we receive correct payment, we will make our contractual adjustment and send you a bill for any balance due. Co-pay and deductibles are to be paid on the date of service.

NON-PARTICIPATING PLANS:

As a courtesy to you we will bill your insurance carrier if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account within 30 days, the balance will be assessed for payment. You should remit payment within 30 days or contact your insurance company to check on status of the claim. Please notify us immediately upon contacting your insurance company or if there is anything we can do to help settle this claim. If you have a non-participating Blue Shield plan which will send payments to you instead of to the doctor, we will ask for full payment from you on the day of your visit. Then we will bill Blue Shield on your behalf and Blue Shield will reimburse you directly.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to this Financial Policy.

X _____
Signature Date

ACKNOWLEDGEMENT OF HEALTH INFORMATION NOTICE

I am aware of the Notice of Health Information Practices (HIPAA) and understand that this policy is available upon request.

X _____
Signature Date

ZITELLI & BRODLAND ASF CENTRAL AND ASF SOUTH

IMPORTANT NOTICES

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have received, both verbally and in written format, the Zitelli & Brodland ASF Central and ASF South Patient Rights and Responsibilities information. Furthermore, I have had the opportunity to read the notice, ask questions regarding my rights as a patient and understand all information as presented.

FINANCIAL INTEREST DISCLOSURE

I am aware that my physician may have a financial and ownership interest in the Surgical Facility. I acknowledge that I have elected to have my procedure performed at the Surgical Facility after considering both my physician's financial interest in the Surgical Facility and my choice to have the procedure performed at a different facility.

ADVANCE DIRECTIVES

I acknowledge that I have been informed that Advance Directives do not apply during the time of procedure at the Surgical Facility. I understand that all life saving measures will be taken during my procedure at The Facility even if I have a fully executed Advanced Directive to the contrary.

If I do have Advance Directives at the time of my admission to the Surgical Facility, and I provide a copy, it will be placed on my record.

In the unlikely event that an emergency arises, and I need to be transferred to the hospital for further care, my Advance Directives will be sent with my chart to the receiving hospital.



By my signature below, I acknowledge that I have received the aforementioned notices provided by the Surgical Facility prior to the date of my procedure, or if my procedure has been scheduled the same day as my referral, I have received the notices prior to the Surgical Facility obtaining informed consent for the procedure to be performed.

Signature _____

Date _____

Patient _____

Time _____

Print Name

(Complete only if receiving notice on the same day as procedure)