Lawrence W. O'Holleran P.C.

General Surgery

Patient Financial Responsibility Statement

Thank you for choosing Lawrence O'Holleran P.C. for your general surgery needs. We are committed to providing you with quality care.

Patient Financial Responsibilities

- It is the patient or guardian responsibility to be aware of your insurance coverage, policies and any exclusions or limitations as well as any authorization requirements. Please contact your insurance to obtain your benefits prior to your surgery.
- We will notify your insurance of the scheduled procedure and bill your insurance for you, however, it is your responsibility to provide us with your most current updated insurance information. You will be responsible for the entire amount of charges if your insurance is not in effect at the time of service.
- Co-payments and co-insurance payments and deductible amounts are the patient or guardian responsibility. These amounts are due within 90 days from the receipt of billing unless other arrangements are made with our billing service.
- Every attempt is made to authorize your surgery with your insurance carrier prior to the procedure. You will be responsible for any services that Dr. O'Holleran believes are medically necessary based on the current standard of quality medical care and are later denied by your insurance.
- Your surgery may require an assistant surgeon and an anesthesiologist is required for all surgeries. The charges for these services are separate from Dr. O'Holleran and the Surgery Center. You will be responsible for these additional charges for your surgery.
- Self-pay procedures must be arranged prior to the actual surgery. Our office can assist you with arrangements, however agreed upon amount must be paid in full prior to the surgery.
- You will be responsible for payment of the following additional charges:
    a) $25.00 will be charged for checks returned for insufficient funds.

I have read the above statements and understand that regardless of insurance coverage, I am responsible for payment of this account. I agree to the terms of the Financial Responsibility as outlined above.

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Signature of Patient or legal guardian Date

_____ _____

Printed Name Relationship to Patient