Arrow Surgical Associates, P.C.

Insured Patient Financial Policy Notice

Patient Name: _____ Date: _____

Thank you for selecting our practice for your healthcare services. Our office utilizes an outside billing service. As a courtesy to you, they will bill your insurance provider for all services we render you. Once the payment or denial is received from you insurance company(s) you will receive an invoice for your balance, it is considered due upon receipt.

For all surgeries a portion of your deductible, whether in network or out of network, is due within 5 business days of your scheduled surgery unless we direct you otherwise.

Your signature below acknowledges your understanding and your agreement to comply with the above terms.

Signature: _____ Date: _____
(if minor, parent or legal guardian signature required)

Arrow Surgical Associates, P.C.

Health **I**nformation **P**atient **P**rivacy **A**ct

Complaints Complaints about your privacy rights or how this practice has handled your health information should be directed to our Privacy Officer by calling our office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200
Independence Avenue SW
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name – PLEASE PRINT

_____ _____

Patient's Signature Date

_____ _____

Authorized Faculty Signature Date