Akkary Surgery Center
1100 Fort Pierpont Drive, Suite 101 Morgantown, WV 26508
Phone: 304-241-1100 www.akkarysc.com Fax: 304-983-8800

This agreement represents a contract between you and Akkary Surgery Center (referred to here as ASC). It is provided to allow for a clear understanding and a positive mutual relationship concerning payment for services, fees, and billing procedures at ASC.

I (Name)_____(Date of Birth) _____ understand that it is my responsibility to the following:

1- As a courtesy, ASC agrees to do the initial and subsequent billing to my insurance company or companies.

2- To provide ASC with the correct insurance information

3- To provide ASC with my correct address and contact information

4- To contact ASC immediately with any insurance and/or contact information changes

5- To pay my Co-Pay on the date of service

6- That outstanding allowable patient responsibility (e.g. deductible, co-insurance) will be billed to me.

7- Of ASC to send me monthly statements via mail/email.

8- That my balance is due in full within 30 days of the date of the statement.

9- That any balance older than 90 days may lead to referring my account to collection/ law firm.

10- To know my balance and pay it on time even if I don't receive a statement.

11- That ASC accepts cash, check and major credit cards.

12 That a $50.00 Service charge will be billable to me for any returned (bounced) check.

13- Of ASC or their representative(s) to answer any question(s) I may have regarding my account.

14- That the facility charges (e.g. hospital) are separate from the professional services charges (e.g. Surgeon).

15- To know my insurance benefits.

16- To forward payments, sent directly to me from my insurance company, to ASC if the payments represent unpaid services provided to me by ASC.

17- To know if my insurance company requires pre-authorization or referral before receiving service(s) by ASC.

18- If I choose to use ASC services without required pre-authorizations, referrals or network participation, I agree to be financially responsible.

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19- That not showing up for my appointments or cancelling on a short notice is holding a time slot that can be given to another patient. It is my responsibility to notify ASC if I need to cancel or reschedule an office appointment. If I fail to arrive for a scheduled office appointment without contacting ASC at least 24 business hours prior to the scheduled time, I might be subject to a "NO-SHOW" fee (The fee is $100 for a “new” patient visit and $50 for an “established” patient visit).

20- That not showing up for my endoscopy or scheduled surgical procedure at ASC, Hospital or other facility or cancelling on a short notice might hold a time slot that can be given to another patient. It is my responsibility to notify ASC if I need to cancel or reschedule a procedure appointment. If I fail to arrive for a scheduled procedure appointment without contacting ASC at least 48 business hours prior to the scheduled time, I might be subject to a "NO-SHOW" fee (The fee is $300).

21- That if I use any tobacco products and the day of my surgery’s lab results show an increase in nicotine levels (whether through ABG, CarboxyHgb, etc.,), that my surgery will be canceled, and I will be billed and will pay $300.00.

22- That each time I request any Human Resource paperwork (e.g. Family Medical Leave/Short Term Disability) or similar paperwork to be complete, I will be charged a fee of $25.00. I understand that it is my responsibility to review the paperwork for correct completion if requesting it to be emailed to myself rather than sent directly to my HR/employer.

23- That I might be required to sign an ABN (Advanced Beneficiary Notice) if applicable.

24- To pay any outstanding balance in full prior to receiving further elective services.

25- I agree to pay my out of pocket responsibilities (e.g. deductible, coinsurance, etc...) prior to proceeding with surgery. I understand that this amount is a rough estimate and might change after my insurance processes the claim. If I owe a balance after the insurance claim processing, then I agree to pay this balance in full within 30 days of the date of the statement. If ASC owes me a balance after the insurance claim processing, then I will contact ASC to request a refund. I understand that I have the option of keeping the balance on my account for future services.

I, the undersigned, hereby confirm that I have read and understood this agreement and I agree with all the terms listed above.

Patient's Name: _____ ASC representative Name: _____

Patient's Signature: _____ ASC Representative Signature: _____

Date: _____ Date: _____