



Akkary Surgery Center

1100 Fort Pierpont Dr., Suite 101, Morgantown, WV 26508

Phone: 304-241-1100

www.yourdreambody.com

Fax: 304-983-8800

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

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

- 1- As a courtesy, the office agrees to do the initial and subsequent billing to my insurance company or companies.
- 2- To provide the office with the correct insurance information
- 3- To provide the office with my correct address and contact information
- 4- To contact the office 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 Akkary Surgery Center 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 Akkary Surgery Center accepts cash, check and major credit cards.
- 12- That a \$50.00 Service charge will be billable to me for any returned (bounced) check. As of June 1, 2019, Akkary Surgery Center no longer accepts personal checks; however, if a personal check is mailed through the postal service, is cashed, and is returned (bounced), the \$50.00 service charge applies.
- 13- Of Akkary Surgery Center 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 Akkary Surgery Center if the payments represent unpaid services provided to me by the office.
- 17- To know if my insurance company requires pre-authorization or referral before receiving service(s) by the office.
- 18- If I choose to use Akkary Surgery Center services without required pre-authorizations, referrals or network participation, I agree to be financially responsible.
- 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 the office if I need to cancel or reschedule an office appointment. If I fail to arrive for a scheduled office appointment without contacting the office at



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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 the office, 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 the office 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 the office owes me a balance after the insurance claim processing, then I will contact the office 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 Name: _____ Akkary Rep Name: _____

Patient Signature: _____ Akkary Rep Signature: _____

Date: _____ Date: _____