



## Financial Responsibility Acknowledgement

Dear Patient:

Thank you for choosing Stonecreek Surgery Center as your healthcare provider. The following is our financial policy. If you have any questions or concerns about our payment policies, please do not hesitate to contact our Billing Department at (702) 589-4900.

Payment for services is due at the time services are rendered. We accept cash, check, or credit card. We will submit an insurance claim on your behalf. You must notify us immediately if your insurance information changes.

**You must understand and sign that you acknowledge the following:**

1. Your insurance policy is a contract between you, your employer, and the insurance company.
2. You have the right to waive your insurance at anytime. If you do not inform us of your insurance carrier information at the time of service, you could be responsible for all fees incurred at the time of service.
3. You are responsible for knowing your insurance benefits. What are non-covered services in your plan? What is your deductible and/or co-payment for outpatient surgery? Does your plan require a primary care physician (PCP) referral? If we can be of assistance, please let us know.
4. You are responsible for any deductible or co-payment that will be applied to the surgery center at the time services are rendered. You may pay by cash, check, or credit card.
5. Returned checks are subject to a return check fee of \$25.00.
6. A 1.5% interest rate will be added to any patient outstanding balance over 30 days.
7. Financial arrangements for services must be made prior to services being rendered through the Billing Department. You may contact them at (702) 589-4900.
8. If your account goes to Collections, you are responsible for any Collection fees, Legal fees, and/or Court fees.

I hereby acknowledge that I have read and understand the above read material and agree to the terms.

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Patient (Patient Representative) Signature

\_\_\_\_\_  
Date

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