

PATIENT BILLING AGREEMENT

Dear Patient,

Presently, Fellowship Surgical Center is not a participating provider with various insurance carriers.

It is sometimes the policy of the insurance carriers NOT to pay the providers who are not participating with them, but to pay the patients instead. This means that after your insurance carrier has processed your claim(s) for the facility charges, all payments and their corresponding explanation of benefits will go to you (the patient) and not to Fellowship Surgical Center.

Please note that this only applies to claims for Fellowship Surgical Center, not your other healthcare providers such as your physician, lab chargers, anesthesia charges or radiology charges.

This letter is to serve as an agreement noting that when you do receive the check and explanation of benefits from your insurance carrier for services rendered to you by Fellowship Surgical Center, you will immediately forward them to our office. Again, please remember any funds you receive belong to Fellowship Surgical Center for services you received.

I, _____, agree that when I receive any checks, explanation of benefits, or other correspondence relating to the services rendered to me at Fellowship Surgical Center from my insurance company, I will immediately forward them to the business office.

I understand that I will be held entirely accountable for any outstanding or unpaid balances on my account until I have turned over any and all checks I have received from my insurance carrier to Fellowship Surgical Center.

Patient Signature _____ Date _____

Witness _____ Date _____