Bloomfield Hills Surgical CENTER

STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Bloomfield Hills Surgical Center for you surgical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:
The patient (or patient's guardian/legal representative) is ultimately responsible for the payment of treatment and care.

- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles, and all other procedures not covered by their insurance plan.
- It is the patient's responsibility to know what services are covered under their individual insurance plan.
- Patients may incur, and are responsible for payment of additional charges, if applicable.
- I understand that my financial responsibility to Bloomfield Hills Surgical Center is separate from my physician's professional fee and anesthesia fee.

By signing below, I understand that I am financially responsible for any and all charges not covered by my health insurer for services provided by Bloomfield Hills Surgical Center.

☐Patient ☐Parent of Minor ☐Legal Representative

_____
Name (Print)

_____ _____
Signature: Date: