AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance. However, you are responsible for your copay and/or percentage for which the insurance company is not liable on the day of your visit. It is also the patient's responsibility to obtain referrals from their primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service.

I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorized the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I understand that I will be given a full copy of Salem Surgical's Financial Policy upon request. The outstanding balance on my account is due and payable within sixty (60) days of the billing date as shown on my monthly statement. (If you have insurance, your balance is due sixty days after payment by your insurance company.) If it is necessary for my account to be referred to a collection attorney there will be collection fees of 25% of the unpaid balance plus all court costs. In the event that your account becomes delinquent (90 days & over), a finance charge of 12% (1% per month) will be added to your account.

I agree that Salem Surgical may contact me by telephone at any telephone number associated with my account, including wireless numbers which could result in charges to me. They may also contact me by sending text messages or emails. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device. I certify that I have been made aware of the roles and services offered by the physician and I consent to care by him/her. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____

Signature Date

_____

Salem Surgical Employee - Signature

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.

_____ _____

Signature Date

Print Name: _____

_____

Salem Surgical Employee – Signature REVISED 9/1/23