Financial Policy

SONORAN SKY SURGICAL

Thank you for choosing Sonoran Sky Surgical, PLC for your medical care. The following financial policy is in place to assist you with any questions you may have regarding your financial obligation to this practice.

1. We will do our best to verify that your insurance plan is contracted with our office for the services you may need. However, we strongly recommend that you also check with your insurance. Please be aware of both benefits and exclusions associated with your specific plan, as an services not "covered" by your insurance will be your financial responsibility. If further assistance is needed in clarifying this information, please reach out to us and we will do our best to help. All claims submitted to your insurance company are completed as a courtesy to our patients

2. Please keep us updated if your insurance information has changed at any point in time while you are undergoing treatment. This could change your copays and eligibility for service. If we are not aware of insurance changes, your insurance may deem you ineligible for services we have provided. You will be billed for provision of these services.

3. You are responsible for any portions of your bill not covered by insurance. If you are billed for any balance, payment is required within 30 days of receipt of a bill. Secondary insurance claims are filed as a courtesy, and become the responsibility of the patient if any payment is not received within 60 days of filing a claim.

4. In order to serve you today, your insurance may require a copay. If so, this requires our office to collect your assigned copay at the time of your appointment. If you are unable to pay your copay at the time of your appointment, please work with our staff in rescheduling your appointment at a time that is convenient for you. As your condition requires continued medical attention, our office will assist as best we can to accommodate your needs and ensure your health care requirements are met. We are unable to "bill" you for missed copays. If your insurance plan includes a deductible, this is due at time of procedure scheduling or you will risk having your procedure cancelled.

5. If you do not have health insurance, or we are not contracted with your particular insurance, you will need to pay for services prior to receiving them. Self-pay accounts are eligible for a discount. However, this discount is not applicable if a payment plan is initiated. If you do not adhere to the arrangements of your plan, your account will be referred to collections. If your account is referred to a collection, you will be responsible for all additional costs.

6. If you require documents to be filled out by the office for programs such as FMLA, short-term disability, etc, we have a service fee of $25.00 to cover the time spent processing. Additionally, this paperwork will not be completed until after you have had your surgical procedure, as the details required may not be known until after your surgery is completed.

7. If you do not provide us with at least one business day notice of an appointment cancellation, a $25.00 cancellation fee will be charged. Please recognize that we dedicate time prior to your visit to collect and review your personal and health information so that we can try to ensure a productive visit. When you do not show up for this visit, we are unable to provide care for other patients.

8. We accept cash, check, credit and debit cards. We strongly advise processing of credit/debit cards in person if surgery pre-payment is required. If a personal check is returned for insufficient funds, a $25.00 fee added to your account.

BILLING INQUIRIES

If you have any questions regarding a bill you received from our office, please contact our billing office Old Pueblo Practice Management at (520) 722-3777. Their office hours are 8:30am-5:00pm, Monday-Friday (excluding holidays).

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read, understand, and agree to the financial policy of Sonoran Sky Surgical, PLC. Regardless of my insurance status, I understand I am responsible for payment for any professional services rendered. I authorize the release of any medical information necessary to process a claim for benefits under my policy and assign payment to Sonoran Sky Surgical, PLC,

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____