



Surgery Procedure Information

Patient name: _____

DOB: _____ Date/Time of Surgery: _____

Facility: Asheville Surgery Center Orthopedic Surgery Center Mission Hospital

INSURANCE:

It is the policy of our office to collect all applicable deductible and/or co-insurance amounts at your pre-op visit prior to your scheduled surgical procedure. This amount is based on your surgical insurance benefits obtained from your insurance company. Our scheduler will meet with or call to give you this amount prior to your surgical insurance benefits. We will file an insurance claim on your behalf following your surgical procedure. We provide the insurance company with a copy of the operative report for processing your claim. Sometimes the insurance company will request additional information from the insured, and we ask that you respond immediately to prevent a delay in processing your claim. If there is a balance remaining after your insurance company has processed the claim, then a statement will be sent to you. The balance owed by the patient is required within 30 days, unless prior financial arrangements have been made. Should you have any questions regarding your account with our office, you can contact our billing/insurance department.

Routine post-operative office visits are included in the surgical fee for 0, 10, 30, 45, 60 and 90 days (global period) after the date of your surgery depending on the procedure(s). **Such items not included in the global period are any necessary x-rays, casts, braces, supplies, or other durable medical equipment (DME).** After your global time period, all follow-up clinic visits will incur a charge, and you will be responsible for your co-pay/co-insurance amount as set by your insurance company. If you have a new problem, we would be happy to address it as a separate charge but deductible, co-pay and co-insurance would apply.

Should you require therapy services post operatively, these charges are separate and are not included in your surgical fees. You will be responsible to pay any applicable co-pay, deductible and/or co-insurance as per your therapy benefits for each visit.

Please be advised that in addition to the billing from Carolina Hand and Sports Medicine, you will be receiving separate billing statements from other medical providers involved with your surgery. These providers may include but are not limited to: an assistant surgeon, a physician assistant, the surgical facility, anesthesiologist, pathologist and (IPG) surgical equipment. Should you have questions regarding billing statements from these other providers, please contact the number on the statement you received.

We are dedicated to your wellbeing and sincerely appreciate the opportunity to serve you as a healthcare provider.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____
(if pt under 18 years old)