

**PAYMENT OF ACCOUNT**

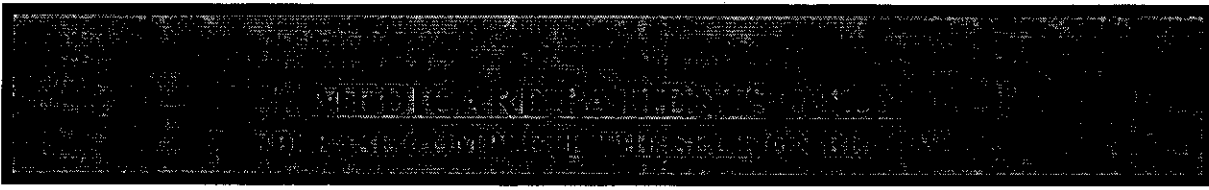
We file claims to your insurance company for you. If they do not respond within 90 days, you will then become financially responsible for the balance. Furthermore, we charge what is usual and customary for our area. You are responsible for payment regardless of any (commercial) insurance company's discretionary determination of usual and customary rates.

I hereby authorize my insurance carrier to pay Surgical Associates of Neenah, S.C. directly for services rendered.

I further authorize Surgical Associates of Neenah, S.C. to furnish information to my insurance company (ies) concerning my illness and treatment for the purposes of obtaining reimbursement for medical services provided.

I understand and agree that I am responsible for payment of my account regardless of my insurance status.

\_\_\_\_\_ *Responsible Party/Patient Signature* \_\_\_\_\_ *Date*



**PATIENT SIGNATURE ON FILE FOR MEDICARE CLAIMS**

Entitlee's Name \_\_\_\_\_  
(Last) (First) (MI)

Medicare Number: \_\_\_\_\_

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Surgical Associates of Neenah, S.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**I AUTHORIZE MEDICARE TO FORWARD MY CLAIMS DIRECTLY TO MY SUPPLEMENTAL INSURANCE CARRIER** \_\_\_\_\_  
**(Name of Insurance Company)**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**This authorization is in effect until I choose to revoke it.**