# Financial Agreement

- **REFERRALS**- If your plan requires referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. Failure to attain a referral will hold you responsible for that day's services.
- **CO-PAYMENTS**- By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **SELF – PAY PATIENTS**- Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **Medicare/Medicaid**- I request that payment of Authorized benefits be made on my behalf and I permit a copy of this authorization to be used in place of the Medicare form.

**WE ACCEPT CASH, CHECKS, MASTERCARD, VISA OR DISCOVER CARD**

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

Thank You for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I hereby authorize direct payment of surgical/medical benefits to Cliff P. Connery, M.D. and/or Faiz Y. Bhora, M.D. Department of Thoracic Surgery; for services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance or for all charges for services rendered by the above physicians if I am not covered by any insurance policy or plan.

Patients Name: ____________________________ DOB: _____________________

Responsible Party Signature: ________________ DATE: _____________________

Print Name: _______________________________ Relationship:_______________