Laird + Laird
Surgical Associates, PLLC

Summary of Financial Policies & Notice of Privacy Practices

Summary of Fees

Fee Name	Reason	Charge
No show appointment	Cancel or reschedule appointment less than 24 hours notice	$25
No show surgery	Cancel or reschedule surgery less than 7 days before surgery	$100
Returned Check	Bank returns check for any reason	$40
Declined credit card	Credit card on file is declined	$40
Late payment	Bills not paid in full within 30 days of billing date An additional fee if not paid in full within 60 days of original billing date	$35
Surgery Deposit	Deposit to reserve a date for surgery. Applied to outstanding balance. Refundable if surgery is cancelled or rescheduled with 7 days notice.	Good Faith Estimate

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I understand that the above fees are not covered by any insurance plan, including Medicare and Medicaid, and will be my responsibility to pay these fees. Exceptions to this fee schedule will be at the sole discretion of the management of Laird and Laird Surgical Associates, PLLC, and will only be made for unusual and extenuating circumstances.

Your insurance company determines how much you owe. We will bill your insurance company on your behalf. Your insurance company will determine the portion you are required to pay, based on your insurance policy. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit or prior to your surgery.

If we are not enrolled in your insurance plan, your visits and surgery will be considered “Out of Network”. All out of network services must be paid in advance and in full for any office visit or surgery. You will then be given a “Super Bill” to submit to your insurance for reimbursement, which might cover all, some, or none of the charges based on their policies.

If you are not sure if Dr. Raymond Laird or Dr. Cristen Laird are in your network, please call your insurance company to verify before your appointment.

We accept cash, check, and all major credit cards. **We do not offer payment plans or financing.**

Co-pays and outstanding balances or fees are due **before** being seen on the day of your appointment.

Patients with deductibles will need to either pay the outstanding deductible plus co-pay amount or $200, whichever is less, before being seen. After your insurance is billed, any outstanding balance owed will be billed to you. Any overage will be applied to your account or refunded.

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To confirm your date of surgery, a good faith estimate of your cost share is required as a deposit. This will be used towards the final amount you owe for your surgery. The final amount you owe is determined by your insurance, and might be slightly more or less than the good faith estimate. It is refundable. However, if you cancel your surgery less than 7 calendar days before, a cancellation fee applies.

A bill will be sent to you after the insurance claim is filed, your insurance company determines your cost share, and we have had time to apply this information to your account. **A $35 late fee will be charged if the bill is not paid in full by the due date,** which is 30 days after the bill is printed**.** A second notice will be sent with the late fee applied. If the second bill is not paid by the due date, an additional $35 late fee will be added, and we reserve the right to assign your balance to a collection agency.

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Minor and Parent or Guardian Responsibility

I understand that whoever accompanies my child to their appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services.

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I acknowledge my responsibility for payment of all services provided by Laird and Laird Surgical Associates in accordance with the practice's fees and terms.

Notice of Privacy Practices

I have read a copy of Laird and Laird Surgical Associates' Notice of Privacy Practices. A written copy will be provided to me at any time upon my request. It is also available on the practice website www.lairdsurgical.com

Assignment and Release

I authorize payment to be made directly to Laird and Laird Surgical Associates, PLLC by my insurance company, **and I accept financial responsibility for all services not covered by my insurance**. If my insurance sends payment to me directly, I will forward and endorse that insurance check to Laird and Laird Surgical Associates, PLLC to cover services rendered. I understand that failure to do so is insurance fraud. I authorize release of any medical care information requested by my insurance company required for payment of my insurance claim. My signature below acknowledges that I have read and understand this information.

Acknowledgement of Summary of Financial Policies & Notice of Privacy Practices

By signing below, I agree that I have read the entire Summary of Financial Policies & Notice of Privacy Practices of Laird and Laird Surgical Associates, PLLC. I can request a written copy of the financial policy or privacy practices, or I can view a copy at www.lairdsurgical.com. The policies can be updated at any time without written notice. **I have asked for clarification on any items that were unclear to me before signing.**

Name (please print): ____

Signature of Responsible Party: ______________________________________

Relationship to Patient: ☐ Self ☐ Other: ____________________

Note: The financially responsible party must sign this form and provide a valid photo ID before the patient can be seen. It is for your protection and to prevent fraud.

Updated March 2023