South Anchorage Surgery Center
1917 Abbott Rd Suite 103, ANCHORAGE, AK 99507
9079298790

Financial Policy

Thank you for choosing South Anchorage Surgery Center. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment in our office.

All patients (parents or guardians) must complete our Patient Information and Financial Policy prior to any procedure.

- PAYMENT IS DUE AT THE TIME OF SERVICE
- WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD
- WE OFFER A PAYMENT PLAN WITH PRIOR BUSINESS OFFICE APPROVAL
- THERE WILL BE A $25.00 SERVICE FEE CHARGE ON ALL NSF CHECKS

Regarding Insurance:

It is our goal to provide fast and efficient billing as a courtesy to you. We need your help to accomplish this goal by providing complete and accurate insurance information. Knowledge of your deductible and co-pays is your responsibility. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If for any reason your insurance coverage changes, it is your responsibility to inform South Anchorage Surgery Center in a timely manner. If you fail to inform us within 60 days of the change, the South Anchorage Surgery Center will not be responsible for filing your insurance. Please be aware that some, and perhaps all of the services provided may be non-covered services. Some insurance companies reduce or deny benefits saying they are not considered UCR (usual, customary, or responsible). Please be advised that our fees are based on a national geographic standard and are, in face, UCR for Alaska.

The Facility bill is separate from the physician's bill

The total cost for many medical services is comprised of two fees. Each fee is now billed separately by the provider of the services. The facility fee covers the cost of providing the facility, nurses, equipment and supplies involved in caring for you.

I understand that I am fully responsible for any and all charges for services rendered by the South Anchorage Surgery Center. If insurance information is provided, my insurance company will be billed a s courtesy to me. I am responsible for my portion of the bill at the time that services are rendered. I hereby authorize payment under my insurance to be paid directly to South Anchorage Surgery Center providers and I further authorize release of any information necessary to my insurance company for payment of claims. I understand a finance charge of 1.5% will be applied to any outstanding balance due after insurance payment or denial after a 90-day grace period.

All deductibles and co-pays are due and payable at the time of treatment

The balance is your responsibility whether your insurance company pays or not. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates:

Our Practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Minor Patients:

The adult accompanying a minor, the parents (or legal guardians) of the minor, are responsible for payment.

I have read, understand, and agreed to the Financial Policy.