AVANTÉ SURGICAL

4780 Village Plaza Loop, Suite 100 Eugene, Oregon 97401
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Financial Agreement

It is your responsibility to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current photo ID and insurance cards should be presented at each office visit. As a courtesy, we will file your insurance claim for you. If you are a Medicare patient we will bill Medicare and your secondary insurance.

Financial Agreement:
I understand that I am responsible for the payment of services rendered if the services are not covered by my insurance for any reason. AVANTE SURGICAL, LLC, is a participating provider with most health plans, however, participation is subject to change. I understand it will be my responsibility to verify with my insurance carrier the plan participation status of your surgeon (KRISTIAN FERRY, MD or JOHN TERHES, MD) prior to a service being rendered. Insurance will be according to the billing/payment guidelines of my primary insurance contract. If a referral is required by my plan I understand, it is my responsibility to obtain or my insurance may not pay my claims.

Payment Agreement:
Co-payment, deductibles, co-insurance, non-covered services (including pre-existing conditions) and services denied due to lack of referral are my responsibility.

Assignment of insurance Benefits:
I assign medical benefits paid by my insurance carrier(s) to be sent to AVANTE SURGICAL, LLC and/or the rendering physician. I acknowledge that I will be billed for charges not covered under my insurance policy as well as those portions indicated as my responsibility.

Additional Charges:
There may be additional medical services ordered by us, such as laboratory or radiology, for which you will be referred out of this clinic. If this occurs, you will receive a separate billing from that provider, for which you will be responsible.

Release of Information:
I authorize AVANTE SURGICAL, LLC to furnish insurance company(s), employer, other payer(s) or their representative's any and all information required to process my claim. Special permission is necessary to release the following information: drug/alcohol abuse, mental health or HIV related conditions.

Patient Balance:
I agree to pay any balance remaining on my account upon receipt of a statement. I understand that if I fail to pay the balance on my account this may result in Avanté Surgical pursuing any collection means possible If my account becomes delinquent, it will most likely be forwarded to an outside collection agency (Quick Collect, Inc., phone: 800-252-6322). If this happens, I will be responsible for all costs of collection, including but not limited to, interest, rebilling fees, court costs, attorney fees and collection agency costs. At minimum, a $20.00 fee is added when refereed to collections and interest will begin accruing. If it becomes necessary, court costs and attorney fees typically start at $210.00.

I have read and I understand Avanté Surgical's Financial Policies, and I accept Responsibility for the payment of any fees associated with my care.

Patient Name:_____ DOB:_____

Signature of Patient (or Guardian):_____ Date:_____