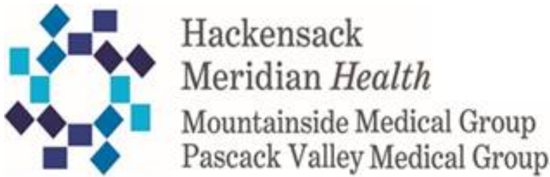

CHARGES FOR SURGICAL PROCEDURES

Name: Test Test **Patient Number: 191447**

Precertification: Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for physician and hospital services. If you have any questions regarding pre-certification for the provider's professional fee, please contact our Pre-Certification Department at **(201) 644-9520**.

Professional Fees: This is the fee billed by your doctor for his/her services in performing your procedure. These fees are within the range considered usual and customary for this area. We will pre-certify the PROFESSIONAL portion of your procedure regardless of where your procedure is done. If you have an unmet deductible and/or have a copay greater than $100, you will receive a call before your procedure from our billing department. You will be responsible for any deductibles, coinsurance or copayments applicable per your plan.

Facility Charge: This is the fee billed by the place of service where the procedure is performed. A facility charge will apply to all procedure sites. We will pre-certify for the procedure sites listed below with the exception of Rockland & Bergen Surgery Center. Rockland & Bergen Surgery Center will get their own pre-certification.

Procedure Site	Facility Billing Company	Phone Number
Bergen Gastroenterology	Bergen Gastroenterology	Pre-procedure (201) 483-2691 Post-procedure (866) 270-8965
Hackensack Meridian Health – Pascack Valley Medical Center	Hackensack Meridian Health – Pascack Valley Medical Center	(201) 383-1035
Hackensack Meridian Health – Hackensack University Medical Center	Hackensack Meridian Health – Hackensack University Medical Center	(551) 996-3355
Patient Care Associates, LLC	Patient Care Associates, LLC	(201) 567-8090
Rockland & Bergen Surgery Center	Rockland & Bergen Surgery Center	(201) 307-4810
Surgical & Endoscopy Center of Bergen County	Endoscopy Center of Bergen County (Paramus Endoscopy)	(201) 336-1100
Surgicare Surgical Associates of Mahwah	Surgicare Surgical Associates of Mahwah	(201) 834-1100
The Stone Center of NJ	The Stone Center of NJ	(973) 563-8548
Valley Hospital	Valley Hospital	(201) 291-6080

_____ I understand I am using my **in-network** benefits for the facility charge. I understand that although the surgical center is contracted with the insurance company, my insurance plan may still hold me responsible for a deductible and/or coinsurance.

_____ I understand I am using my **out of network** benefits for the facility charge. This facility is not contracted with my insurance company to provide services. I understand that the reimbursement may be sent to me instead of the facility. Upon receipt of the insurance payment, I will forward the check and the explanation of benefits to the Center. In addition, I understand that my insurance plan may still hold me responsible for any deductibles and/or coinsurance.

CHARGES FOR SURGICAL PROCEDURES

Pathology: If a biopsy is required during the course of your treatment, a tissue sample will be sent to a pathologist for interpretation. You may receive a separate bill from the pathologist (Premier Medical Alliance LLC, Miraca, Endo Diagnostics, Pathline, CBL, HUMC, Valley or Mayo Labs). The amount will vary depending on the number of pathology samples taken during the procedure. The billing office cannot quote you the total cost for pathology, as multiple biopsies can be taken during the procedure. **Initials _____**

Insurance: According to our records, you have as your insurance coverage. You are responsible for notifying our office of any insurance changes that you may have. If you change insurance carriers or will be changing prior to your procedure, please contact our Registration Department immediately at 201-483-2694.

I understand, that I am seeing a specialist and it is my responsibility to obtain a referral, if required by my insurance. I also understand that my deductibles, copays, and/or coinsurance, according to my insurance plan, will be my responsibility.

Fees: I understand I can possibly be billed for some or all of the following fees: Professional Fee (the doctor's charge for performing the procedure), Facility Fee (the use of the surgical suite during the procedure), Anesthesia Fee, Pathology Fee. Yes, I understand the fees associated with the procedure. **Initials: _______**

Patient Rights: I acknowledge that I have received a copy of the Patient's Rights and HIPAA Privacy Regulations.

Ownership Disclosure: (this does not apply to HUMC- North at Pascack Valley and Valley Hospital)
I have been notified that my physician may have a financial interest in this center and anesthesia providers and that I have a choice to go to another facility. ______Yes ______ No

Patient Signature: The undersigned certifies that this form has been fully explained to him/her, and the undersigned is satisfied that he/she understands its content and significance.

_________________________________ 08/10/18 ___________________________
Signed: Test Test Date Witness

Name: Test Test
Patient Number: 191447