Anesthesia
Associates of
Central Kansas, P.A.

200 S. 5th Street
Salina Ks 67401
Phone 785-827-2238 Fax 785-827-1684
www.aack.org
Please contact our office with any questions. Thank you!

Statement of Patient Financial Responsibility

Patient Name ____________________________________

Anesthesia Associates of Central Kansas (AACK) appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in, implies a financial responsibility on your part. Electing to participate in medical services causes an implied financial responsibility. Services rendered at other facilities will be billed separately.

As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately a patient's responsibility to know their coverage and benefits.** You authorize AACK to furnish information to insurance carriers concerning your care. You are responsible for any amount not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full.

A down payment may be required on the day of service(s) subject to your co-payment, deductible, co-insurance and/or out of pocket expenses.

I understand that I am responsible for co-payments, deductible, co-insurance and/or out of pocket expenses.

Initial______________

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due.

Initial______________

Cancellation/No Show Policy

I understand a 24-hour notice is required for all appointment cancellations or reschedules. Reminder calls are made 24-48 hours prior to your appointment. It is up to the patient to keep all contact information updated at AACK.

Fees and/or dismissal from AACK may occur for not showing for a scheduled appointment without proper notice.

Initial______________

I have read the above policy regarding my financial responsibility to AACK. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to AACK. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

______________________________	______________________________	____________
Signature patient OR parent/guardian	**Print Name**	**Date**
______________________________	______________________________	____________
Witness Signature	**Print Name**	**Date**