AKKARY
Surgery Center

1100 Fort Pierpont Dr. Suite 101, Morgantown, WV 26508

Phone: 304-241-1100 www.yourdreambody.com Fax: 304-983-8800

FINANCIAL AGREEMENT

This agreement represents a contract between you and Akkary Surgery Center (referred to here as Akkary Surgery Center or the office). It is provided to allow for a clear understanding and a positive mutual relationship concerning payment for services, fees, and billing procedures at Akkary Surgery Center.

I (Name)_____(Date of Birth) _____ understand that it is my responsibility to the following:

1. As a courtesy, the office agrees to do the initial and subsequent billing to my insurance company or companies.
2. To provide the office with the correct insurance information.
3. To provide the office with my correct address and contact information.
4. To contact the office immediately with any insurance and/or contact information changes.
5. To pay my co-pay on the date of service.
6. That outstanding allowable patient responsibility (e.g. deductible, co-insurance) will be billed to me.
7. Akkary Surgery Center will send me monthly statements via mail/email.
8. That my balance is due in full within 30 days of the date of the statement.
9. That any balance older than 90 days may lead to referring my account to collection/ law firm.
10. To know my balance and pay it on time even if I don't receive a statement.
11. That Akkary Surgery Center accepts cash, cashier's check, and major credit cards.
12. I understand that no cash monies over $50 per visit will be accepted by Akkary Surgery Center. I will pay my responsibility with another form of payment. I also understand that no personal checks are accepted by Akkary Surgery Center.
13. That a $50.00 service charge will be billable to me for any returned (bounced) check.
14. Akkary Surgery Center or their representative(s) to answer any question(s) I may have regarding my account.
15. That the facility charges (e.g. hospital) are separate from the professional services charges (e.g. Surgeon).
16. To know my own insurance benefits by calling my insurance company prior & during my plan of care.
17. To forward payments, sent directly to me from my insurance company, to Akkary Surgery Center if the payments represent unpaid services provided to me by the office.
18. To know if my insurance company requires pre-authorization or referrals before receiving service(s) by the office.
19. If I choose to use Akkary Surgery Center services without required pre-authorizations, referrals or network participation, I agree to be financially responsible.
20. That not showing up for my appointments or cancelling on a short notice is holding a time slot that can be given to another patient. It is my responsibility to notify the office if I need to cancel or reschedule an office appointment. If I fail to arrive for a scheduled office appointment without contacting the office **at least 24 business hours prior to the scheduled time**, I might be subject to a "NO-SHOW" fee (The fee is $75.00).
21. **Cosmetic Patients**: A surgical deposit of $500 is required to book your surgery. **This deposit is non-refundable**. Surgery space is limited and therefore your deposit cannot be refunded once paid. Please be aware that this deposit is deducted from your surgery costs. The remainder is collected at your pre-op visit which is approximately two weeks prior to your surgery date. Quote does not include hospital fees (if applicable) preop labs/testing, medications, garment(s), supplements, or additional supplies if needed. In house financing option is 50% of the total cost down with the remainder paid to the

business in 6 months. When paying with Care Credit or the in-house option, no discount is applied. (Column 1 on invoice) If refund occurs, the institution's interest charge from a Care Credit transaction is deducted from the paid in amount. Pre-op appointment cancellation requirement is **24 hours prior** to the appointment time. (The fee is $75) Surgery date cancellation requirement is **2 weeks prior** to the surgery date. (The fee is $500) Should your cancellation not meet the requirements; a charge may incur (The fee is $500). Office policy is enforced that one surgery reschedule is allowed and cancellation fee will be returned to the patient once the procedure is completed. If the surgery is cancelled a second time**, within 24 hours of the arrival time**, the entire funding for the procedure is forfeited to Akkary Surgery Center to cover the fees associated with scheduling, OR time, medications, staffing, etc. When a second procedure is quoted the discount will apply when procedures are performed together. If patient opts to separate the procedures the original price supersedes.

22. That not showing up for my endoscopy or scheduled surgical procedure at the office, hospital, or other facility, or cancelling on a short notice might hold a time slot that can be given to another patient. It is my responsibility to notify the office if I need to cancel or reschedule a procedure appointment. If I fail to arrive for a scheduled surgery procedure appointment at Akkary Surgery Center without contacting Akkary Surgery Center at least **2 weeks prior to the scheduled time**, I might be subject to a "NO-SHOW" fee (The fee is $500). This non-refundable information was also listed on the invoice I was given at the time of my initial appointment. If I fail to arrive for a scheduled procedure appointment at a hospital without contacting Akkary Surgery Center, I might be subject to a "NO-SHOW" fee (The fee is $500).
23. That if I use any tobacco products and the day of my surgery's lab results show an increase in nicotine levels (whether through ABG, CarboxyHgb, etc.,), that my surgery will be canceled, and I will be billed for the non-refundable amount and will pay $500.00.
24. That each time I request any Human Resource paperwork (e.g., Family Medical Leave/Short Term Disability) or similar paperwork to be complete, I will be charged a fee of $25.00. I understand that it is my responsibility to review the paperwork for correct completion if requesting it to be emailed to myself rather than sent directly to my HR/employer.
25. That I might be required to sign an ABN (Advanced Beneficiary Notice) if applicable.
26. To pay any outstanding balance in full prior to receiving further elective services.
27. I agree to pay my out-of-pocket responsibilities (e.g., deductible, coinsurance, etc...) prior to proceeding with surgery. I understand that this amount is a rough estimate and might change after my insurance processes the claim. If I owe a balance after the insurance claim has been processed, then I agree to pay this balance in full within 30 days of the date of the statement. (This includes all inpatient care/visits at United Hospital Centers or Preston Memorial Hospital, Commercial, Medicaid, Medicare, and all branches of each insurance company)
28. It is the patient's responsibility to contact Akkary Surgery Center for any refund(s) posted to their account and while we do our best to identify any refunds, we cannot guarantee identifying all refunds or being able to contact all patients accordingly.
29. For Bariatric Patients- There will be a $50.00 fee for required Nutrition classes as a part of your journey. That fee is **Non-refundable** after 24 hours in which payment has been made.
30. Grievances may be given to the Practice Manager or the Practice Administrator in person, by email: kkimble@yourdreambody.com, asmoot@yourdreambody.com, by phone: 304-241-1100, or fax: 304-983-8800. If the issue is not or cannot come to an agreement, the patient is welcome to notify the Board of medicine : Address: 101 Dee Dr Unit 103, Charleston, WV 25311 Phone: (304) 558-2921 Website : https:/ / wvbom.wv.gov/ public/ search/

If the office owes me a balance after the insurance claim processing, then I will contact the office to request a refund. I also understand that refunds may be paid in monthly installments back to me after a thorough investigation of the account is completed. This may take up to 90 business days. I understand that I have the option of keeping the balance on my account for future services. I, the undersigned, hereby confirm that I have read and understood this agreement and I agree with all the terms listed above.

Patient Name: _____ Akkary Rep Name: _____

Patient Signature: _____ Akkary Rep Signature: _____

Date: _____ Date: _____