



Patient Surgery Cost Sheet

*Courtesy, Betsy Sharp, Administrator, Orthopaedic Associates Surgery Center LLC in Augusta, Ga.
December, 2005*

SURGERY CENTER NAME

Patient:	Chart #:		
Date of Surgery:			
Surgeon:			
Estimated Facility Fee:			
1 st Procedure: \$	2 nd Procedure: \$		
Estimated Facility Fee:			
3 rd Procedure: \$	4 th Procedure: \$	Total: \$	
Estimated Primary Insurance Payment:			
\$	Estimated Insurance write off amount: \$		
Patient's Primary Insurance:	Phone #:		
Estimated Secondary Insurance Payment:			
\$			
Patient's Secondary Insurance:	Phone #:		
Estimated Patient Responsibility:			
Deductible \$	+ (____%) \$	+ Co-pay \$	= Total: \$

The charge and patient responsibility quoted above is an estimate. If any additional procedures are performed or special equipment used, you will be billed accordingly. Your physician, laboratory, pathologist, anesthesiologist, or radiologist will send you separate bills for their services, as they are not employees of the surgery center.

Remember that your insurance policy is a contract between you and your insurance company. We will file your insurance claim for you. However, you (the patient) are ultimately responsible for payment of your medical bills.

Payments can be made via cash, check, MasterCard, or Visa. Thank you for your cooperation in this matter. Please do not hesitate to call us at **PHONE NUMBER** if you have any questions concerning the arrangements regarding your surgery.

Patient Signature: _____ Date: _____

COMPANY INITIALS Representative: _____ Date: _____

White: Office

Yellow: Patient