(Practice Name)

SURGICAL COST ANALYSIS

Patient' Name: _____

Today's Date: _____ Proposed Surgery Date: _____

Procedure Code(s) Diagnosis Code(s) Fee(s)

_____

_____

_____

Financial Responsibilities:

Our Charges: $_____

Plan Allowable: $_____

Non-Covered Services: $_____

Deductible: $_____

Coinsurance: $_____

Your Total Responsibility: $_____

Total Deposit Due (% of Total Responsibility) $_____

The deposit is due ___ days prior to surgery. We will accept a personal check, cashier's check, VISA/MasterCard, or cash. The balance of your financial responsibility is due at least____days prior to surgery unless other arrangements are made.

Our fee includes all post-operative visits for____days after the date of surgery.

Lab tests are extra and are billed by the laboratory service.

Our fee quotations are valid for____days.

If you have any questions, please call me. I am your Surgery Coordinator.

Surgery Coordinator Signature:_____Phone: _____

Patient Signature: _____ Date: _____