



**NORTH POINTE
SURGERY CENTER**

170 North Pointe Blvd. Lancaster, PA 17601 (717) 735-6650 northpointesurgery.com	1701 Cornwall Road Suite 100 Lebanon, PA 17042 (717) 277-7009
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We are happy your surgeon has scheduled your procedure with North Pointe Surgery Center (NPSC). As a courtesy to you, we have contacted your insurance carrier to verify your benefits and coverage.

This letter is to make you aware of your estimated patient responsibility for the facility fee. This is not a guarantee of the final amount due after your surgery. The amounts listed below are estimated based upon your specified procedure and the date of verification. * *Please note amounts listed are subject to change.*

Please note your procedure will generate three separate bills:

1. Facility (North Pointe Surgery Center)

Covers the use of the facility and necessary supplies used during surgical procedure.

2. Surgeon (Orthopedic Associates of Lancaster)

Covers the services provided by your physician with Orthopedic Associates of Lancaster.

3. Anesthesia (OAL Anesthesia)

Covers the anesthesia services provided to you during your procedure.

Your Estimated Benefits

Insurance Company: _____ Date of Estimate: _____

Deductible Remaining: _____

Coinsurance: _____ Copay: _____

Total estimated out-of-pocket expense for the facility fee: \$ _____

Please be prepared to pay this amount prior to or at time of registration on the date of your procedure. If you have questions regarding your insurance benefits, please call your insurance provider for clarification.

PREPAYMENT INFORMATION

Online: Visit www.northpointesurgery.com. Click on the "Patient Information, followed by "Pay My Bill"

Accepted payment methods: Cash, Check, Visa, MasterCard, Discover, CareCredit and HRA or HSA accounts

Mail: Complete the bottom portion of this form and return it to:

North Pointe Surgery Center
170 North Pointe Blvd
Lancaster, PA 17601

Patient Name: _____ MRN: _____ Date of Procedure: _____

Form of Payment: Check Visa MasterCard Discover

Name on Card: _____ Amount: _____

Card Number: _____ Exp. Date: _____ Security Code: _____

Billing Zip Code: _____