595 North Courtenay Pkwy, Ste. 103.
Merritt Island, Florida 32953
Ph# 321) 890-1800 . Fx# 321) 890-1819

Today's Date: _____

Account Number: _____

Space Coast Surgery Center is an out of network facility with my insurance company _____.

I understand that as a courtesy to all patients who are out of network, Space Coast Surgery Center has agreed to honor my in-network benefits rates as payment in full.

I am aware that the facility will collect any copayments and/or coinsurance percentages as if I were in network.

I am aware my insurance company may send me payment for the service provided at the facility. Under Florida Law, I agree to endorse this insurance check to the facility within 30 days of receipt. Failure to do so could result in my account being forwarded to the Credit Bureau for the payment in full.

_____ _____
Patient Signature **Date**

_____ _____
Witness (Front Desk) Signature **Date**

CC: Medical Billing Solutions, LLC
SCSC Patient File


Space Coast
Surgery Center