Financial Responsibilities for Surgery

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Phone Number: [Insert Phone Number]

Dear [Patient Name],

We are reaching out to confirm your scheduled surgery on [Insert Date of Surgery] at [Insert Hospital/Clinic Name]. It is important to understand your financial responsibilities before proceeding with the surgery.

Estimated Surgery Costs

- surgeon's fee: $[Insert Amount]
- anesthesia fee: $[Insert Amount]
- facility fee: $[Insert Amount]
- additional costs: $[Insert Amount]

Payment Responsibilities

You are responsible for the following payments:

- Deductible: $[Insert Amount]
- Copayment: $[Insert Amount]
- Coinsurance: [Insert Percentage]% of the total cost

Insurance Information

Please ensure that your insurance information is up to date. Contact your insurance provider for details regarding your coverage.

Payment Options

We offer various payment plans to assist you with managing your financial responsibilities. Please contact our billing department at [Insert Phone Number] for further details.

We appreciate your attention to these matters and look forward to providing you with excellent care.

Sincerely,

[Your Name]
[Your Title]
[Hospital/Clinic Name]
[Contact Information]