[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: Statement of Financial Responsibility for Elective Surgery

Dear [Patient Name],

This letter provides important information regarding your upcoming elective surgery, [Procedure Name], scheduled for [Date] at [Facility Name].

Please review the estimated financial breakdown below:

- **Estimated Total Facility Fee:** $[Amount]
- **Estimated Surgeon/Physician Fee:** $[Amount]
- **Estimated Anesthesia Fee:** $[Amount]
- **Estimated Insurance Coverage:** $[Amount]
- **Estimated Patient Out-of-Pocket Responsibility:** $[Amount]

Terms and Conditions:

1. **Estimates Only:** The figures provided are estimates based on current information and your insurance provider's preliminary benefits. Actual costs may vary depending on findings during surgery, complications, or changes in insurance processing.

2. **Insurance Verification:** While our office assists with verification, it is your responsibility to confirm that the procedure is a covered benefit under your specific plan and that all pre-authorizations are active.

3. **Payment Requirements:** A deposit of $[Deposit Amount] is required by [Due Date] to secure your surgery date. The remaining balance is due [Timeline, e.g., on the day of surgery/within 30 days of billing].

4. **Separate Billing:** You may receive separate invoices from the facility, the surgeon, the anesthesiologist, and any laboratory or pathology services involved.

Acknowledgment:

By signing below, you acknowledge that you have read this statement and understand your financial obligation for this elective procedure.

_____
Patient/Guarantor Signature

_____
Date

If you have any questions or wish to discuss payment plan options, please contact our billing department at [Phone Number].

Sincerely,

[Your Name/Practice Name]
[Contact Information]