

# **Notice of Financial Policies**

## **Insurance Coverage**

Patients are responsible for checking to make sure our physicians participate in their health plan's network. If your insurance requires a primary care provider (PCP), our physician must be the one listed. We cannot be responsible for changes in your insurance. Your co-payment is set by your insurance company, and it is due whenever a patient receives services in the office. We accept cash, credit cards and checks. If you cannot pay your co-pay at the visit, we will bill you for the co-pay and will be assessed a billing fee. If we cannot confirm your coverage with your insurance or you are without insurance, we request that you pay in full at the time of service. Patients are responsible for knowing their medical benefits prior to the visit please call your insurance to confirm your deductible, coinsurance and non covered services.

## **Non-Covered Services**

If we provide services to you that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature below constitutes agreement to pay for such services.

## **Self-Pay Patients**

If you have no health insurance coverage, we offer a 20% discount off the billed charges **if you pay at the time of service.**

## **Cancelled and Missed Appointment**

To meet your appointment needs, please call us 24 hours in advance if you need to cancel or reschedule your appointment. A fee between \$30.00 to \$100.00 will be charged for all appointments cancelled without a minimum of 24 hours notice. This cancellation policy helps us optimize our physician's schedules.

## **Medical Forms and Medical Records**

Most forms will be completed free of charge when presented during the scheduled appointment. Forms requested at other times may be assessed a fee. There is a charge for a copy of your medical records, unless you are requesting it to be sent or faxed to another health care provider. STORAGE??

## **Payment Plans and Returned Checks**

If you cannot pay your account, please speak with our billing specialists to request special arrangements. All returned checks are assessed a \$25.00 fee. If we receive a check back from your bank, we will be unable to accept future payments for services paid by check.

## **Overdue Accounts**

Payments are due at the time of service or on receipt of statement. If necessary your account will be assigned to a collection agency and you will be responsible for any additional finance fees.

***By signing below, I acknowledge that I have read the above financial policies.***

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guarantor's Signature