OFFICE FINANCIAL POLICY

The last several years have been a time of profound change regarding health care reform. It has become necessary to implement the following policies.

PLEASE READ THOROUGHLY AND SIGN THIS SHEET ON THE BACK

1. We will collect your deductible, co-pay, uncovered services or the percent you are responsible for at the time of your visit. Please be prepared to pay at the time of check-in, before you are seen by the doctor. A $15.00 fee will be assessed for any co-payment not made at the time of service**. It is the patient's responsibility to know the terms of their insurance plan.**

2. You must bring your insurance card and photo I.D. with you and any authorization information you may have. Without these, we will be unable to see you.

3. We will file your insurance if we are providers for your plan. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should.

4. If your insurance denies payment on your account you will be asked to pay by check, cash or charge. If you do not pay in a timely fashion, you will be responsible for any and all charges not paid by your insurance company in accordance with the laws. Should your account become delinquent and over 90 days old, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

5. In accordance with AMA CPT guidelines, we reserve the right to charge for telephone calls with our medical professionals that include evaluation and management of your medical condition. We will bill your insurance for such calls, but if it is not covered by your plan you may be responsible for the charges.

6. HMO or PPO PATIENTS REQUIRING A REFERRAL: You are responsible for making sure your visits with our office are authorized by your primary care

physician (PCP). **This authorization must be obtained *before* your scheduled visit.** It is the patient's responsibility to make sure we have received authorization. **If you do not have the proper authorization, your appointment will be rescheduled and you may be subjected to a $50.00 charge for a missed office visit or a $100.00 charge for a missed procedure.**

7. SELF-PAY PATIENTS: This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash and money orders. We will provide you with a receipt.

8. Should you need to **cancel or change your office visit appointment**, you will be subject to a **$50.00 charge** if you do not do so with **24 hours business day advanced notice**. Should you need to **cancel or change an appointment for a procedure**, you will be subject to a **$100 charge** if the change is not made with **2 business days advanced notice**. By signing below, I agree that I am financially responsible for any charges incurred for missed appointments in which I did not give the required advanced notice.

AS A FINAL NOTE:

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.

If you have any questions regarding this financial policy, please ask or call BEFORE you are seen by the doctor.

_____ _____

Patient or Guardian Date

_____

Print Name

03112010