

OFFICE FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. In order to keep our fees to a minimum, we require that you pay at the time of service so that we do not have to send bills. In order to achieve the clinic goals of providing the finest medical care at the lowest cost, we need your assistance and understanding of our payment policy.

The following is included in your initial bill:

- Initial office visit and examination
- Communication by phone and/or letter to your primary medical doctor concerning the initial visit
- Information booklets
- Review of previous medical records
- Analyze current and previous laboratory and radiological information

Not included in initial bill:

- Review of biopsy slides. You will receive a separate bill for reading of liver biopsies. This interpretation will not be filed with your insurance company and you will be directly responsible for this service.

Self-Pay:

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and major credit cards.

Insurance:

PAYMENT OF CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. Service may be denied if payment is not made at check-in time. As a courtesy to our patients, our office will file an insurance claim for services rendered, but ultimately you are responsible for the bill. By law your insurance company must remit payment or deny your insurance claim within 45 days of initial notice. If your insurance company has not paid your account in full within 60 days, we may ask for your assistance in getting your insurance company to pay the balance or the balance may be billed to you. We will file the claims to your insurance company but your insurance policy is a contract between you and your insurance company. We are not a party to that contract and so your balance will be due immediately.

Insurance Coverage Changes:

In the event that your insurance coverage changes to a plan where we are **NOT PARTICIPATING PROVIDERS**, you will be responsible for payment of all fees at the time service is rendered. We ask that you participate in any disputes with your insurance carrier regarding your policy guidelines and insurance payments.

Financial Responsibility for Minors:

Unless prior arrangements have been made, charges for a minor child seen in the office will be the responsibility of the adult accompanying the minor child.

Cancellation Policy:

There will be a procedure cancellation fee of \$75.00 for cancellations of less than 48 hours. Fee is not applied toward surgical fee, or insurance, and is non refundable. This also applies to patients not keeping their appointments.

Returned Checks:

Returned checks are subject to a \$25.00 charge, returned checks older than 30 days may be subject to an additional \$50.00 charge.

As we stated above, the primary goal of our practice is to provide the finest medical care and services to the people in our community. Since our practice also has financial obligations that must be met, we ask that all patients pay for their co-pays and deductibles at the time of service.

I have read, understand and agree to abide by the financial policy set forth.

Signature of patient/Responsible Party

Date