PATIENT RIGHTS AND FINANCIAL RESPONSIBILITY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or Office Manager. We are dedicated to providing the best possible care and service to you. Your complete understanding of our financial policies is an essential element of this service.

1. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **payment is due at the time services are rendered.** For your convenience we accept VISA, Master Card, American Express and Discover. We also accept cash, checks, and money orders.

2. If you are unable to pay your co-payment and/or balances, your appointment may be rescheduled.

3. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

4. We have made prior arrangements with many insurers, managed care companies, and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement. **We will require you to pay any applicable co-payments, deductibles, co-insurance and any outstanding balances at the time of service.**

5. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered"; **you will be responsible for the complete charge.** Payment is due upon receipt of a statement from our office.

6. For all services provided in the hospital by our doctors, we will bill your health plan. Any balance due is your responsibility and we will bill you for these balances.

7. For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

8. In order to provide the best possible service and availability to all our patients, please call as early as possible if you know you will need to reschedule your appointment. A service fee may be applied for no-shows.

9. A $35.00 service fee will be charged for all returned checks.

10. FMLA and Disability paperwork is completed for a charge of $25. Medical records can be copied for a charge of $20. Please allow sufficient time for this to be completed.

11. For male patients only, we will require you to pay all outstanding balances before Sildenafil or Trimix is sold to the patient.

12. I, the undersigned agree to pay any and all charges related to the collection of this bill including, but not limited to, collection charges, court costs, legal fees and service charges incurred by reason of nonpayment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Printed Name of Patient (Date of Birth) Witness

_____ _____

Signature of Patient (or responsible party if a minor) Date

05/01/2016