Financial Policy and Consent for Payment

I, ____, understand that my insurance company may or may not pay for the visit/procedure. I also understand that I am responsible for co-payments, co-insurance, and any in/out of network deductibles. I am responsible for any referrals / pre-authorizations required by my insurance company.

I agree to be 100% responsible for payment if my insurance company denies reimbursement. An authorization / pre-certification is not a guarantee of payment.

APPOINTMENT CANCELLATION & NO SHOW FEES (FOR OFFICE PATIENTS): I agree that there will be a $50.00 fee assessed to my account if I fail to cancel my appointment at least one business day in advance of my scheduled time. There will also be a $50.00 charge if I fail to show up for my appointment.

ADMINISTRATIVE FEES: Returned checks ($30.00); Letters ($50.00); Completion of Forms ($50.00)

Payment can be made to Adult and Pediatric Clinic, P.C. by cash, check, or credit card (MasterCard or Visa). I agree to provide a current credit card number to Adult and Pediatric Clinic, P.C. and I understand any personal account balance greater than 90 days after the invoice date will automatically be charged to that credit card. My credit card information is given below:

Circle One: MasterCard / Visa

NAME ON THE CARD ____

CREDIT CARD NUMBER ____

3 Digit Code on the back _________________ EXPIRATION DATE __________________

It is my responsibility to keep my credit card information current at all times by calling or writing to Adult and Pediatric Clinic, P.C., if necessary.

The financial and insurance information provided by me to Adult and Pediatric Clinic, P.C. is true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney fees and cost of collection in the event of default. I authorize my insurance company to send payments directly to Adult and Pediatric Clinic, P.C.

PATIENT'S NAME (PRINT) ____

SIGNATURE OF PERSON WHO COMPLETES THIS FORM _______________________________

YOUR RELATIONSHIP TO THE PATIENT ____

DATE ____