OUR OFFICE FINANCIAL POLICY

BASIC POLICY: **Payment is due at the time services are rendered**. The office will accept the following instruments for payment of services rendered: Visa, Mastercard, Discover, American Express and Cash.

- To assist our patients, we offer financial arrangements thru a third party vendor. Please ask our office staff for additional information and/or an application to apply.

If payment has not been made to an account 90 days after service is rendered, and no contact or appropriate arrangements have been made, the account will be referred to the necessary legal authorities.

FOR PATIENTS WITH INSURANCE: **As a service and courtesy to our patients, we will file your primary insurance. This courtesy does not relieve the patient of financial responsibility nor suspend payments until the insurance has paid.** Every effort will be made to estimate your co-payments and deductibles with assistance from your insurance provider. The insurance provider does not guarantee payment during the verification process. The charges for services rendered by this office are the responsibility of the patient or patient guarantor. Co-payment and deductible fees are due at the time of service. Please understand that the insurance provider is a contract between you and your insurance company. **If an insurance carrier has not paid within 90 days of billing, any unpaid professional fees are due and payable in full from you.** Please be advised to follow up with your insurance company to be sure that they are processing your claim.

- This office will file on primary insurance only. It is the patient's responsibility to file with their secondary insurance. Our office will file dental extractions to medical insurance only if required by the dental insurance carrier.
- For patients with no insurance, fees will be due and payable at the time of service.

Please remember your individual health insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Be aware that some of our services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

NON-COVERED SERVICES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. Guarantor/Patient's Signature_____Date_____

PERSONAL INJURY CASES: This office does not accept liens or bill for auto-accident or other liability or lawsuit-related cases. It is the patient's **responsibility** and **obligation** to pay at the time of service.

FOLLOW-UP VISITS/AFTER HOURS: Periodic postoperative office visits may not be covered under your insurance plan; however, these may be required by the attending doctor to monitor your health. A $25.00 fee will be charged to the patient for after hour calls made to the physicians for non-surgical patients.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality care at a low cost to our patients, and in fairness to other patients and the doctor, we require **48 hours** notice when canceling an appointment. There is a **$75.00 fee for office visits** not canceled within 48 hrs prior to the appointment. **Scheduled surgery** appointments require **48 hours** notification to reschedule or cancel, or if you do not show up for the surgery, a **$150.00 fee will be charged** and payable from you. The practice reserves the right to dismiss patients with excessive canceled appointments. A separate policy exists for peak surgery scheduling time during the year (i.e. spring break, summer breaks, and fall/winter breaks).

DELINQUENT ACCOUNTS: Should your account become delinquent for nonpayment, you will be reported to the collection service.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance coverage, please read and sign below:
I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance and any other health plans to Metroplex Surgical Arts, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid was the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Guarantor / Patient's Signature X_____ Date _____

I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I am ultimately responsible for all fees for services provided to me.

Guarantor / Patient's Signature X_____ Date _____

Witness Signature _____ Date _____