

Financial Policy Consent Form

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.

In the event of default, I understand that I am responsible to pay for services rendered including reasonable attorney fees and cost of collection. I authorize my insurance company to send payments directly to Adult and Pediatric Clinic, P.C.

APPOINTMENT CANCELLATION & NO-SHOW FEES

There will be a \$75.00 fee assessed to your account if you fail to cancel your appointment at least two business days in advance of the scheduled time. There will also be a \$75.00 charge if you fail to show up for your appointment.

ADMINISTRATIVE FEES

Returned checks (\$100.00); Letters (\$75.00)

PATIENT'S NAME (PRINT) _____

SIGNATURE OF PERSON WHO COMPLETES THIS FORM _____

RELATIONSHIP TO PATIENT _____

DATE _____