



## PATIENT FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

### INSURANCE CLAIMS

**Primary Insurance:** will file claims with the patient's insurance upon the patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage, but cannot provide documentation, payment may be due at time of service.

**Secondary Insurance:** claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

### PATIENT FINANCIAL RESPONSIBILITY

If no insurance is to be filed by Drs. Daniel C. Coffey, MD, Lucas A. Julien, MD or Razvan C. Opreanu, MD; or if not a participating provider, full payment is due at time of service. Co-payments, deductibles, co-insurance and non-covered services are due at time of service. We accept cash, checks, credit or debit cards. In some situations, you may choose to return payment by mail. All payment arrangements are made with the approval of the Office Manager.

### MINORS/DEPENDENTS

Children under the age of 18 will require the signature of a responsible adult party on the registration form. If any procedures are to be performed that require a separate consent form, the responsible adult must also be present to sign the consent form.

### METHOD OF PAYMENT

Acceptable methods of payment are cash, check, credit or debit cards. There is a \$30.00 fee if a check is returned for insufficient funds.

### ACCOUNTS PAST DUE

Payment from statement is due upon receipt. Non-compliance may result in dismissal. A patient may remit payment in full, or make payment arrangements with approval of the Office Manager, for all outstanding charges owed on account. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

### MISSED/CANCELLED APPOINTMENTS

A 24-hour notice for office visit appointments and 1-week notice for procedure cancellations are required. We reserve the right to charge a fee of \$25.00 for office visits and \$100.00 for procedures that are missed or repeatedly cancelled with less than the required notice as defined.

### ACCOUNT CONSULTATION

Physicians do not discuss financial issues. All account questions and payment arrangements can be discussed with the Office Manager.

### FMLA and DISABILITY FORMS

These forms can take considerable amount of time to complete; therefore, a \$15.00 charge for FMLA and \$25.00 charge for disability, are required each time we complete these forms. These fees must be paid prior to releasing the forms. You must also sign a consent form to release the information to your human resources department and/or your disability insurance company.

Patient Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_