



### Financial Policy


As your physician, we are committed to providing you with the best possible medical care and assisting you with timely insurance filing and payment on your account. To achieve this goal, we need your assistance and understanding of our payment policy.


**Payments for Service is Due at Time Services are Rendered / Self Pay:** We accept cash, credit card, and personal checks. Returned checks less than \$50.00 are subject to a service charge (per Florida statute 832.08) of \$25.00. Checks between \$50.00 and \$300.00 have a fee of \$30.00. For checks greater than \$300.00, the fee is \$40.00. You may also lose your privilege to write checks in our office. If you do not have insurance, a pre-payment amount will be required before your visit. At the end of your visit, the physician will indicate what services were rendered and the balance of your visit is due *prior* to leaving.


**Cancelled / Missed Appointments:** Please provide at least 24 hours notification if an appointment must be cancelled. Patients who do not cancel appointments will be charged a fee of \$30.00. If you miss three or more appointments, you may be dismissed from the practice. *Our answering service does not accept appointment cancellations.*


**Insurance:** Our office participates with most insurance companies. For your protection, we will require your current/valid insurance card along with your photo identification. This information will be kept in our records and assist us in filing your insurance claim. Please keep us informed of any changes in your health care coverage. **Co-payment and Deductible's must be paid at the time of service.** These amounts are determined by your insurance company depending on your plan. Because we are under contract with specific insurance companies, we will file your insurance claim directly. After filing your claim, we will allow sixty days for your insurance company to make the payment. **If your insurance company fails to render payment, you will be responsible for the payment in full.**

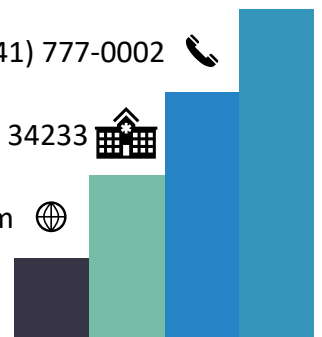
**Medicare:** You are responsible for your annual deductible and 20% of the allowable charges due at the time of service unless you have supplementary insurance. *Please bring your Medicare Explanation of Benefits (EOB) showing that you have met your deductible.*

(941) 777-0002 

3920 Bee Ridge Rd, Building E, Suite E, Sarasota, FL 34233 

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**HMO/MCO:** If you are required to select a PCP by your insurance carrier, then you must change your PCP prior to scheduling an appointment with our office. **If this is not done and your insurance carrier declines payment you will be responsible for the office visit in full based on our fee schedule.**


**Financial Agreement:** We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. However, you must realize that:


- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. At the time of your visit, we will verify your insurance benefits. This information obtained is not a guarantee of payment and final eligibility/benefits are not determined until the claim is received and processed by your insurance company.
- Not all services are a covered benefit in a contract. Some insurance companies select certain services they will not cover. If we are unable to verify coverage and/or eligibility, you will be required to make a pre-payment. Please refer to the clinic's fee schedule for this amount.


*We must emphasize that as your medical care provider, our relationship and concern is with you and your health, not your insurance company.*


**Forms Completion:** Any form requiring completion will have a fee associated with it and must be pre-paid. We do understand form completion may be time sensitive and will be processed as quickly as possible. According to the Florida Statute 395.3025, we are allowed to charge for copying medical records, actual postage, and sales tax. Please refer to the clinic's fee schedule for those amounts.

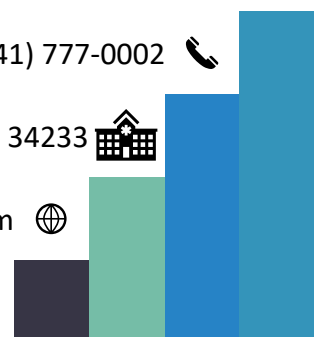
**Worker's Compensation/Automobile Accidents:** We are unable to treat any patient that is seeking treatment related to an accident, injury, and/or illness involving but not limited to: Worker's Compensation, Automobile Accidents, and any other circumstance that may have present or future litigation.

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**All charges are your responsibility from the date services are rendered.**


Any balance on your account after 90 days, including those that insurance has not paid, may result in a collection action. We realize that emergencies do arise and may affect the timely payment of your account. If such extreme cases do occur, **please contact our billing staff promptly for assistance in the management of your account.** We are willing to work with you on setting up a payment plan. A late penalty of 1.5% monthly (18% annually) is added to any unpaid personal balances after sixty days. All accounts with balances over ninety days will be referred to our collection agency.


If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.


If you have any questions about the above referenced information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you. **BY SIGNING BELOW, YOU ACCEPT AND CONFIRM THAT YOU HAVE READ AND FULLY UNDERSTAND OUR FINANCIAL POLICY.**

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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