



PATIENT QUESTIONNAIRE AND RELEASE FORMS

Your insurance policy is a contract that exists between you and our insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Financial Policies:

COPAYMENTS: It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

DEDUCTIBLES & COINSURANCE: If you have a high deductible plan, we may collect a \$125 deposit to apply towards your deductible and coinsurance. Any remaining balance after submission to your insurance company is your responsibility.

SELF- PAY: (for non-covered products and services and for patients without insurance coverage): Full payment is due at the time of service. A down-payment will be required before seeing the doctor. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

REFERRAL: If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

NO SHOW: (failure to present for your appointment): A 24-hour notice is required for cancellations. Missed appointments may incur a \$50 fee for established patients and \$100 for new patients.

SURGERY CANCELLATION: Failure to provide 5 business days notice before surgery will incur a \$450 fee.

BALANCES/COLLECTION FEES: If payment of an outstanding balance is not received within 30 days from the post mark date of a mailed statement or e-statement time stamp, a \$10 rebilling fee may be added to each additional statement. Our patient portal offers the ability to view statements and submit payments conveniently and securely. Patients with balances more than 90 days overdue will be turned over to collections and a \$35 administrative fee will be applied.

RETURN CHECK FEE: A \$35 fee will be assessed for all returned checks.

FMLA/DISABILITY/MEDICAL RECORDS: There is a \$30 charge for having the doctor complete these forms. Requested forms will be completed within 5-7 business days of diagnosis and care plan. The same \$30 fee will be incurred to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient name: (Printed) _____

DOB: _____

Patient/Guardian Signature _____

DATE:: _____

Has your Insurance coverage changed since your last visit?

- Yes
- No

If so, who is your new coverage through? _____