



Suburban Healthcare Associates

## Suburban Healthcare Associates Financial Policy 2016

### Payment

Payment is expected in full for your **estimated** insurance co-payment's, co-insurance, and deductible at the time of your visit, unless other arrangements have been made with the Business Administrator. Please be prepared to pay. We accept the following forms of payment:

- Cash, Check, Debit, Visa, MasterCard, Discover, and American Express
- We offer monthly payment plans through automatic deductions

### Insurance

Our office is committed to helping out patients maximize their benefits. Your insurance policy is a contract between you and your insurance company. As a medical provider, we are not party to that agreement. We require our patient(s) to provide us with their up-to-date medical insurance; without this we are unable to estimate coverage for a patient. **Failure to provide us with your current medical insurance will result in payment in full for services rendered.** Understand that prior verification of insurance coverage is only **ESTIMATION** and **never a guarantee of payment per** the insurance company. If there is a lack of payment from the **insurance company within 60 days, GUARANTOR** will then become responsible for the entire balance **IN FULL**.

**Copays, coinsurance and deductibles are due at the time of service.**

### Minors

Payments for services of the treatment of minors are the responsibility of the adult accompanying that minor.

### Failed appointment Policy

Our office requires a 24 hour notice to cancel or reschedule an appointment. We understand unforeseen circumstances may occur. In the event an appointment is failed/cancelled within less than 24 hours from the scheduled appointment time, we ask that the patient contact our Billing Department to inquire about the service fee. The Fee for missed appointments or rescheduling same day appointments without a 24 hour notice is \$25.00 which must be paid in full prior to patient's next appointment.

### Patient Record(s) Release

Please note that a \$25.00 per person fee is assessed for records release and must be received prior to records being processed in addition to the signed records release form. This assessment is not to exceed \$100.00 per family. You can also request your records be emailed; this is at no charge. We ask you allow 5-7 business days for processing (max). Please keep this in mind when requesting your records.

### Returned Checks

We charge a \$35 fee for returned checks which you are responsible for.

### Collection Fees

Fees incurred to collect payment and/or Collection agency fees will be payable by the patient's account holder.

### Financial Consent

This patient agrees to be fully responsible for total payments of treatment performed in this office regardless of estimated insurance coverage presented. **I understand and agree to this Financial Policy and Agreement.**

### PLEASE FILL OUT EACH LINE COMPLETELY IN THE SECTION BELOW

#### Signature on File

I understand that I am responsible for all treatment not covered by my insurance and failure to remit payment can and will result in forwarding my account to collections.

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Patient's Name ( <b>PRINT</b> )	Patient's Signature	Date
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(If patient is a minor) Responsible Party ( <b>PRINT</b> )	(Signature)	Date
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I hereby authorize payment directly to Suburban Healthcare for the group benefits otherwise payable to me.

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Patient's Name ( <b>PRINT</b> )	Patient/Responsible Party Signature	Date
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