

Financial Policy

Welcome to my office. My staff and I are here to serve your healthcare needs and are dedicated to providing you the best care possible. It is important that you understand that you, and not your insurance company are in charge of your healthcare. Please read and sign the following statement of our Financial Policy. If you have any questions regarding our billing policies please be sure you have a satisfactory answer before signing this document.

INSURANCE: Your individual insurance plan is an agreement between you and your insurance company. It is your responsibility to know the specific details of your own plan. It is especially important for you to notify us if there are restrictions regarding referrals, labs, or service to be performed by outside facilities or specialists. You may be responsible for charges if they are not contracted with your insurance company or you have not received proper pre-authorization. You will also be responsible for any, "Non-Covered Services".

Our office contracts with most insurance providers. Please check with our office staff for a complete list. If we are contracted as preferred providers with your health plan, we will bill your insurance company directly; otherwise, your account will be considered a cash account with full payment expected at the time of service. You will be provided with the documentation necessary to bill your insurance company. Please note that laser and other cosmetic treatments always require payment in full at the time of service unless a payment plan has been established.

CO-PAYS: Co-pays are due at each visit and will be collected when you check in. For your convenience we accept payments by cash, check, Visa and MasterCard.

ACCOUNT FEES: A fee of \$25.00 will be charged for each returned check.

RECORDS AND MISSING FORMS: The completion of the physician section of disability forms will incur a \$25.00 administration charge.

PATIENT INFORMATION: You will be asked to fill out a patient information form at your initial visit and each year thereafter. In order to keep your file up to date, please inform us of any changes of information such as insurance, address and telephone number.

MISSED APPOINTMENT: Unless canceled 24 hours in advance, you may be charged \$25.00 for a missed appointment. Please help us serve our patients better by keeping scheduled appointments.

Jon Scott, D.O.

I have read and understand the above stated Financial Policy and freely accept financial responsibility whether or not any service is covered by insurance.

Signature: _____ Date: _____

Print Name: _____