

GULF COAST MEDICAL SPECIALISTS' FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

- 1) Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa/Mastercard/Checks/Cash.
- 2) Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- 3) We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.
- 4) If you are insured by a plan that we do not participate in, we will prepare and send the claim; however, you will be responsible for the full amount due at the time of service and we will refund any monies sent to the office.
- 5) Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office or billing company.
- 6) If your visit is related to an auto accident or work-related injury, this information must be provided prior to seeing the physician and all claim and billing information must be furnished prior to the appointment.
- 7) We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
- 8) Patients who do not keep their appointments or fail to cancel scheduled appointments **without a 24 hour advance notice** may be subject to an administrative fee from \$30.00 to \$60.00 depending upon the length of the scheduled appointment and a minimum fee of \$100.00 for procedures, such as ultrasounds, cardiac stress tests, and DEXA bone density tests.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient or responsible party

Date

Printed Name