

PATIENT'S NAME: \_\_\_\_\_

Thank you for choosing Medical Associates of Drexel Hill as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

- ◆ All patients must complete our Information and Insurance forms before seeing the doctor.
- ◆ FULL PAYMENT OF PATIENT RESPONSIBILITY IS DUE AT TIME OF SERVICE.
- ◆ We accept cash, checks, or money orders.
- ◆ Insurance cards must be presented at initial visit, or patient will need to reschedule.
- ◆ Any necessary referrals must be present at time of service or patient will need to reschedule.
- ◆ All co-pays, deductibles, and payment of non-covered services are due prior to treatment.

**Regarding Insurance:**

**Non-Participating**

Payment for services is due at the time the services are rendered unless payment arrangements have been approved by our staff. We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit. In special instances, we may accept assignment of insurance benefits. Regardless of any prior arrangements, you are responsible for any out of pocket deductible or co-insurance and these amounts must be paid up front. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. ***If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you.***

**Participating**

Please be aware that some, and perhaps all, of the services provided may be non-covered services. It is our policy not to perform those services unless deemed medically necessary.

**Usual and Customary Rates/Non Participating**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Missed Appointments**

Unless canceled 24 hours in advance, our policy is to charge for missed appointments at the rate of \$90 per missed appointment. Please help us serve you better by keeping scheduled appointments.

- ◆ I acknowledge full responsibility for services rendered by Medical Associates of Drexel Hill.
  - ◆ I understand that payment of charges incurred is due at time of service unless other financial arrangements have been made prior to treatment.
  - ◆ I further authorize and request that payments be made directly to Medical Associates of Drexel Hill.
  - ◆ If my insurance prohibits direct payment to a doctor, I hereby instruct and direct you to make out the check to me and mail it as follows: Medical Associates of Drexel Hill, 510 W. Darby Road, 2<sup>nd</sup> Floor Havertown, PA 19083.
  - ◆ I acknowledge that if a referral is required by my insurance, I am responsible for securing that referral.
  - ◆ I have read the Financial Policy, understand it, and agree to the terms of this Financial Policy.

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_