VR Surgical Associates, PA

Dr. Vincent A. Caldarola and Dr. Rachel Lovano

GENERAL SURGERY

COLON AND RECTAL SURGERY

Floresville Office (Main)	Stone Oak Office	Mission Trial Baptist Office	Methodist Plaza Office
497 10th St., Ste. 102	155 E. Sonterra Blvd, Ste. 116	3327 Research Plaza, Ste. 310	4499 Medical Dr., Ste. 250
Floresville TX 78114	San Antonio TX 78258	San Antonio TX 78235	San Antonio TX 78229

(210) 614-3565

(210) 614-3563 (fax)

FINANCIAL POLICY

Thank you for choosing our office. In order to maintain a good working relationship with you, we have established this financial policy so you know what is expected from you at the time of the appointment. We request that you read, agree to, and sign the following policy prior to treatment.

Initial_____Surgery patients with no call, no show or last minute cancellation will be charged a $100 fee for not giving a 48 hour cancellation notice.

1. **PAYMENT FOR SERVICE:** All applicable fees such as: deductible, co-insurance and co-pays must be paid at the time services are rendered. Our office accepts **CASH, CHECK OR CREDIT CARD (VISA, MASTERCARD, OR DISCOVER).** Payments returned to our office for insufficient funds, closure of account and/ or credit card contentment will result in an assessment of **$35.00** applied to your account.

2. Patients being scheduled for surgery are required to make payment unless their insurance pays 100%. **All deductibles MUST BE PAID prior to surgery.** Upon receipt of the Explanation of Benefits (EOB) the patient will be billed for any remaining balances allowed by the insured's insurance.

3. **HMO & PPO REFERRALS:** If your insurance policy requires a written authorization from your Primary Care Physician for an appointment, you must notify your PCP in advance to ensure that the referral is received prior to your visit with our office.

4. **There is a $20 fee for writing letters and/or filling out forms and/or paperwork, e.g.: Letter for Airlines, FMLA, Short Term Disability Forms - etc....**

5. **IN EVENT OF DEFAULT, FOR ANY REASON, PATIENTS, WILL BE RESPONSIBLE FOR ANY AND ALL ATTORNEY FEES, COURT COSTS, AND COLLECTION FEES.**

6. I agree and authorize Dr. Vincent A. Caldarola to use, disclose and receive any medical records deemed medically necessary for my treatment.

7. **ACKNOWLEDGEMENT OF RECEIPT OF THE PRIVACY PRACTICE NOTICE: I, _____, acknowledge that I have read/received a copy of Dr. Caldarola's Notice of Privacy Practice. This notice describes how Dr. Vincent A. Caldarola may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.**

_____

(Signature of Patient or Personal Representative) (Date)

_____

(Relationship to Patient)

WITNESS: _____