Patient Financial Responsibility & Other Services Form

Thank you for choosing the office of Dr. John B. Crescitelli as your physician. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient policies/financial responsibilities, which are as follows:

Financial Responsibility

It is important for you to understand that you, the patient, are ultimately responsible for payment of medical services you have received. Cash, personal check, or credit cards are accepted methods of payment.

Proof of Insurance

We must obtain a copy of your driver's license and a current, valid Health Insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information at each visit you may be responsible for the balance of the claim. **We ONLY accept Traditional Medicare with any or no supplement.**

Past Due Balances

Any balance more than 30 days old will be considered past due. Failure to make payment on a past due balance may result in your account being forwarded to a collection agency. Payment in full is due upon receipt of our statement.

No Show Policy

All scheduled appointments not cancelled within 24 hours prior are subject to a $150 fee. This serves as a notice that repeat missed appointments may result in dismissal from the practice.

Returned Checks

Checks written at the time of your visit or mailed as payment on an account balance that is returned by the bank will be assessed a $100 retuned check charge.

Request of Medical Records

For personal requests, pages 1-25 will incur a charge of $1.00 per page; pages 26 and up will incur a charge of $0.25 cents per page. This is state law.

Request of Mailed Results

For personal requests of results (lab, radiological, etc.), patients who wish to have them mailed to their house will be required to pay a $10.00 processing fee. You may pick up a copy of your results at our office at no charge. Please give 48-hour notice for any results that you would like us to have ready for you.

Request Completion of Forms/Letters by Physician

All Letters/Forms are subject to a $50 charge. Payment is due at the time of request. Completion may take up to 2 weeks to complete.

Medicare and Supplement Insurance Authorization for Assignment of Benefits

I hereby authorize and direct payment of medical benefit to Dr. John B. Crescitelli on my behalf for any services furnished to me by the physician.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility & Other Services Form:

____ ___________

Signature of Patient, Authorized Representative/Guardian Date

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Print Name of Patient, Authorized Representative/Guardian

Thank you for choosing our practice as we strive to provide you with First Class and Compassionate Care!

Custom arrangements can be made with the Doctor to be seen anywhere, including home, any hospital, or vacation locations. For these custom visits there will be a fee for service. NO insurance of any kind will be accepted for custom arrangement.