FINANCIAL POLICY

(PLEASE READ THE FOLLOWING STATEMENTS AND FILL OUT THE BOTTOM INFORMATION)

Thank you for choosing us as your health care provider. We are committed to the quality of your medical care. Please understand that payment of your bill is considered a part of your medical care. The following is the statement of our financial policy which we require that you read and sign prior to your treatment.

The undersigned agrees to whether he or she signs as a guardian or as a patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates him/herself to promptly pay the account to Dr. Schramm. Provisional credit may be allowed for confirmed insurance benefits when assigned by Dr. Schramm. All such provisional credits are subject to collection.

We are happy to accept your insurance at the time of the visit, and while we file with your insurance carrier. This is a courtesy that we extend to our patients. All insurance claims are ultimately your responsibility. Because your insurance is a contract between you and your carrier and does not guarantee payment to our physician, we cannot become involved in disputes regarding your claims, deductibles, copayments, non-covered charges or other denials of payment. It is part of our contractual agreement with any HMO or PPO policy to collect any patient responsibility. If your insurance plan requires a referral form for an office visit to a specialist, you are required to bring it with you at the time of your visit for each appointment. Obtaining your referral is **NOT** the responsibility of this specialty office. In signing the following, you attest that you understand the above and will comply with your insurance plan instructions. Your signature also confirms that if you arrive without a referral, you may: Reschedule your appointment. Accept responsibility for office and other charges for the date in full, paid prior to the office visit.

Should you have any questions regarding your insurance coverage, please direct them to your insurance representative. Your account will be charged a $35.00 service fee for any returned checks. If you fail to pay your account you will be responsible for any collections fees incurred, including small claims court. This may include a 35% processing fee if our account is placed in a third party collection agency. If you request copies of your records there will be a charge of $1.00 per page. **You are hereby advised and acknowledged by the signature below that there will be a $20.00 charge for any missed appointments that are not canceled with at least 24 prior to the designated time of the appointment. This is a non-covered service therefore you will be held personally responsible: not your insurance company.**

The following form authorizes the disclosures of personal health information of the following individuals. This authorization is effective from the date signed until revoked in writing by the patient.

RECORDS RELEASE AUTHORIZATION AND FINANCIAL POLICY AGREEMENT:

PATIENT:_____ DATE OF BIRTH:_____

TO:_____PHONE:_____RELATIONSHIP_____

TO:_____PHONE:_____RELATIONSHIP_____

PATIENT BETWEEN THE AGES OF 12-18 MUST SIGN THE CONSENT TO RELEASE ANY INFORMATION TO THEIR LEGAL PARENT OR GUARDIAN_____ _____

OFFICE STAFF WITNESS

_____ _____

PATIENT/GUARANTOR'S SIGNATURE DATE

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