Financial and Office Policies Please read and initial each line.

_____ All copays and deductibles are due at the time of service. There will be an administrative fee of **$5.00** added to your account if your co-pay is not paid at the time of service.

_____ It is the patient's responsibility to know your insurance benefits and whether the physician you see here is an in-network provider. You will be responsible for any noncovered expenses for using an out-of-network provider. You are responsible to notify the receptionist or nurse where blood work (lab) needs to be sent for testing (i.e. DCH or Lab Corp). Some insurances require referrals to specialists and urgent care facilities. **It is your responsibility to notify our office within 48 hours if you are seeing or have seen another physician!** Do not assume that referrals are done if you do not speak to someone in our office.

_____ We request 24 hours notice for cancellation of an appointment. Your account may be billed a fee of $30.00 for failure to cancel an appointment and "No Showing".

_____ No appointments will be given if your account is past due. (We will be glad to set up a payment plan on your account.) Failure to keep your account current will result in dismissal as a patient of this practice.

_____ In order to release medical records, we must have a signed release on file. For us to release your medical records to another physician for the purpose of changing physicians, your account balance must be paid in full. Accounts not paid in full will be treated as a bad debt and forwarded to our collection agency and any fees associated to this will be your responsibility.

_____ There is a fee and a waiting period on all medical letters, and forms (including copying records, FMLA and disability). Please check with the office staff in advance on the cost for each request.

_____ We require 24 hours notice for all written prescriptions.

_____ Our after hours and weekend telephone answering service is a courtesy and should be used for an emergency only. We **will not** call in any medication or narcotic prescriptions after hours or on weekends.

_____ There is a $30.00 fee on any returned check and we will no longer accept checks as a form of payment on your account. If your check is not picked up within 10 days of our notice to you, we will turn it over to the district attorney's office and you will be responsible for their fees and courts costs.

Agreement To Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, Dr. _____has provided or will provide professional services and I agree to the above financial policy. I understand that failure to comply with this agreement, and if my account becomes more than 90 days past due, it may be turned over to a collection agency, and attorney or small claims court for collection. I understand that any expense incurred by the practice in its attempt to collect claims will be added to my bill and become my responsibility.

I hereby authorize Dr. Katona and his nurse practitioner to furnish medical information to my insurance carriers for payment of claims. I hereby authorize direct payment for medical services rendered to the physician. I understand that I am responsible for any amount not covered by insurance.

_____ _____ _____

Signature of Responsible Party Relationship to Patient Date