FASV, P.C.
FINANCIAL POLICY

Thank you for choosing **FASV, P.C.** As your health-care provider. We are committed to providing quality treatment. Please understand that payment of your bill is considered a part of your treatment. All patients must complete this Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete this information before being seen by the doctor.

Regarding Insurance
We may accept assignment of insurance benefits. However, we require **ALL** copays to be made at time of service. The balance is your responsibility whether or not your insurance pays. We cannot bill your insurance company unless you give us current insurance information and a current insurance card to copy or scan to keep on file. Your insurance policy is a contract between you and insurance company. We are not party to that contract. Please be aware that some and perhaps **all** of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You will be responsible for these balances. If your insurance is a **HMO** and requires a REFERRAL, it is **YOUR** responsibility to obtain that referral and to keep up with when it expires and when you are out of number visits approved before seeing the doctor. If you wish to sign a waiver to see the doctor without a referral you have the choice to do so.

Initial_____

Return Checks
There will be a $50.00 return check fee on **All** return checks. In the event that a check a returned for insufficient funds, we will call your bank to verify funds for any future checks that are presented for payment on your account.

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Collection Fees
In the event that your account is turned over to a collection agency, you will be responsible for all collection cost not exceed 33 1/3% of balance in addition to court and/or attorney's fees and collection agency fees .

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Missed Appointments
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per missed appointment. Please help us to serve you better by keeping scheduled appointment.

Initial_____

Fees for Letters and Forms
Your health care provider will be more than happy to complete the medical portions of any necessary form (s) you may need. Please be advised that there is a fee of $20.00 per form, due to the time required to dictate and complete letters and forms. These costs are considered non-covered by insurance companies and are the responsibility of the patient. A fee schedule is available upon request and payment is to be made upon completion.

Initial_____

Medical Records Request
When you or someone in your behalf request Medical Records on you, we have an outside source who come in and copies medical records. There is a cost for these records, which we do not know the cost and you will need to fill

out a medical records release form before Medical Records are released to you or a third party.

Initial_____

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____ Date: _____

Signature of Patient or Responsible Party

For your convenience, we accept cash, check, and most credit cards (visa, master card, visa check cards)