# Financial Policy: All Patients Please Read and Sign

**Payment is due at the time of service unless arrangements have been made in advance. If you are not prepared to pay for services rendered today, please notify the receptionist before you are seen by the doctor. We accept cash, checks, American Express, Discover, MasterCard, and Visa. Please see additional information below and sign at the bottom of the page.**

**MEDICARE:** We are a participating Medicare provider. Your fees will be based on what Medicare ALLOWS for our services. You will pay only your deductible if it is not met for the year, as well as your 20% co-payment on any charges beyond the deductible amount. You will also be asked to pay for any non-covered services. We will notify you ahead of time if the service to be performed is not covered by Medicare. If you have a secondary insurance and wish us to file on it for you, please notify us so that we may verify the coverage.

**HMO/PPO INSURANCE COMPANIES:** If your insurance company is an HMO or PPO (Preferred Provider Organization) with whom we are associated, you will be required to pay based upon your policy guidelines. ***Co-payments and deductibles are due at the time of service.*** If your policy requires a referral from your primary care physician, it is your responsibility to obtain this and provide us with a copy. If your insurance company denies payment due to no referral, you will be responsible for paying our full fees. ***WE MUST BE ABLE TO VERIFY YOUR INSURANCE COVERAGE BY TELEPHONE PRIOR TO YOUR APPOINTMENT. IF WE ARE NOT ABLE TO DO SO, YOU WILL BE ASKED TO PAY OUR FULL FEES AT THE TIME OF SERVICE. IF COVERAGE IS LATER VERIFIED, WE WILL BE HAPPY TO REFUND YOU ANY OVERPAYMENT ONCE YOUR CLAIM HAS BEEN PROCESSED.***

**SURGERY:** We will file surgery charges with your insurance company, but the final responsibility for payment of all charges is ultimately yours – not your insurance company. If for any reason your insurance company does not pay as anticipated, you will be required to pay the balance. Prior to scheduling surgery, we may require a surgery deposit, depending upon your insurance coverage. This deposit will include pre-payment for any deductible, co-payment, and coinsurance amounts, as well as any non-covered services or supplies to be dispensed from our office.

***Please sign that you have read, understand, and accept our financial policy. This signature also authorizes payment of insurance benefits to the physician and the release of medical records to process your claim (see below):***

Patient signature (parent, if minor) ______________________________ Date ______________

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. THOMAS M. REED OF THE SURGICAL AND MEDICAL BENEFITS OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES NOT PAID BY MY INSURANCE COMPANY. I ALSO AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS(S). THIS AUTHORIZATION SHALL BE VALID UNTIL REVOKED AND A PHOTOCOPY SHALL BE AS THE ORIGINAL.