FINANCIAL POLICY

I, the undersigned, in consideration for services rendered to me by Kenton T. Bruice, M.D., P.C., understand and agree to the following:

1. Any co-payments are required to be paid on the date of service.
2. Payment is due on the date of service with the exception of insurance claims for which Kenton T. Bruice, M.D., P.C. is under contract to file directly. Payment methods accepted: VISA, MasterCard, personal check, cash, and money order.
3. I understand that Kenton T. Bruice, M.D., P.C. is NOT a MEDICARE or MEDICAID provider and that if my primary insurance carrier is Medicare or Medicaid, that I am responsible for full payment on the date of service, and that my secondary insurance will not cover any of the charges.
4. My insurance policy is a private contract between me and my insurance carrier. As a courtesy, Kenton T. Bruice, M.D., P.C. will file my insurance claim for me. It is my responsibility to verify my coverage with my insurance carrier. It is also my responsibility to notify Kenton T. Bruice, M.D., P.C. of any changes to my insurance coverage. Failure to notify from Kenton T. Bruice, M.D., P.C. of these changes will leave me responsible for claims not accepted by my insurance carrier.
5. I hereby authorize Kenton T. Bruice, M.D., P.C. to file with my insurance carrier, and I assign payment of my medical benefits to Kenton T. Bruice, M.D., P.C. In addition, I authorize release of any and all medical records and information necessary to process any claim generated by services I receive from Kenton T. Bruice, M.D., P.C.
6. My insurance coverage may not provide payment for all charges incurred in obtaining treatment from Kenton T. Bruice, M.D., P.C. I will be responsible for any co-payment, deductible, coinsurance, or service “not covered” by my insurance.
7. Appointments are reserved for me alone, therefore cancellation of such with less than adequate notice to the office creates a hardship. I therefore agree to be responsible for the cancellation fee of $100 for cancellations made less than two business days. I understand that these fees are not covered by insurance.
8. Returned checks will incur a $25 fee and accounts turned to collection will be charged a collection fee.
9. I will be charged or an insurance claim will be filed for every office visit and every lab that is drawn at every appointment.

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices and the Financial Policy of Kenton T. Bruice, M.D., P.C. and I agree to be bound by its terms.

_____ _____

signature date

_____

name (please print)