



## ADVANCED LAPAROSCOPIC ASSOCIATES, P.C.

### Financial Policy

Thank you for choosing us as your surgical specialist. We are committed to providing you the best possible care, and we are pleased to discuss our professional fees with you at any time. The following is a statement of our Financial Policy which we require you to read and sign prior to any medical services.

- **FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. NO EXCEPTIONS. IF YOU DO NOT HAVE YOUR CO-PAYMENT, YOU WILL NEED TO RESCHEDULE AND YOU WILL BE ASSESSED A \$50.00 CANCELLATION FEE.**
- ALL PAYMENTS WILL BE COLLECTED UPON CHECKING IN FOR YOUR SCHEDULED APPOINTMENT.
- WE ACCEPT CASH, PERSONAL CHECKS, VISA, AND MASTERCARD.

#### INSURANCE

- **If we are a participating provider with your insurance plan you are responsible for all co-payments, deductibles and any non-covered services at the time of service. Deductibles and an estimated co-insurance must be taken care of prior to surgery.** As a courtesy we will file insurance claims with most insurance carriers, provided you have supplied us with the proper information.
- If we are NOT a participating provider with your insurance plan you are responsible for full payment at time of service. If you need to file your own insurance our office will provide you with the proper documentation.
- Bills for surgery will not include charges of anesthesia, hospitalization, or laboratory test. These are billed separately, from the facility where the surgery is performed.

#### MINOR PATIENTS

The adult parent or guardian accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policy holder is. For unaccompanied minors non-emergency treatment can be denied until a parent or guardian is present or we have written permission for treatment and payment of the account period.

#### WORKMAN'S COMPENSATION

All workmen's compensation claims must be verified in writing by the employer. Verbal or telephone verifications are not acceptable. If you have seen another physician for the same complaint an authorization for a change of physician must be verified on your company's form.

#### PERSONAL INJURY WITH ATTORNEY

If you are being represented by an attorney or a third party payer, we will provide you with the proper information to file your claim. You are responsible for full payment to our office at the time services are rendered.

#### AUTOMOBILE ACCIDENT

If you were in an automobile accident and you have "Med-Pay" automobile insurance our office will provide you with the proper documentation to file the claims. It will be your responsibility to file the claims. If you have health insurance we will file a claim for all professional services received.

#### MISSED APPOINTMENTS

Failure to give 24 hour notice of cancellation of your appointment will result in a \$50.00 fee billed directly to you. We will not bill your insurance company for this amount. You will be responsible for prompt payment of this fee prior to being seen at your next scheduled visit.

#### COLLECTIONS

If your account balance becomes past due and is sent to an outside collection agency, you will be responsible for any additional fees incurred. This will occur if balances are more than 90 days past due.

All monthly statements are due and payable in full upon receipt.  
All returned checks are subject to a \$25.00 service fee.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY. IF YOU NEED TO MAKE SPECIAL PAYMENT ARRANGEMENTS THIS NEEDS TO BE BROUGHT TO OUR ATTENTION PRIOR TO BEING EXAMINED. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

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Signature of Patient or Guardian

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Date