

THE JOHN LAWSON SURGICAL GROUP, P.C.

FINANCIAL PAYMENT POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the doctor.

1. REGARDING INSURANCE: We may accept assignment of insurance benefits from your health care plan however, the doctor's service is provided to you and not your Insurance Company. **Your policy is a contract between you and your insurance company.** Any unpaid balance is your responsibility whether your insurance company pays or not. You will be held responsible for collecting from your insurance company.

In the event that we are a participating provider, all co-pays and deductibles are due prior to treatment. If co-pay is not paid at time of visit, a \$9.00 billing fee will be charged to your account to cover the cost of billing for co-pay. If your insurance coverage changes to a plan that we are not a participating provider with, please refer to the above paragraph.

In the event your insurance situation changes, you are responsible to submit any new information to us as soon as it becomes available. If we are not informed, the first paragraph applies.

2. SELF PAY: In the absence of insurance or in the event that we do not participate with your insurance; full payment is due at the time of service. Special circumstances will be addressed by administration.

3. METHODS OF PAYMENT: We will gladly accept cash, check, or VISA/MASTERCARD. If your insurance plan has not paid their portion of your account in full, the account must be paid within (60) days due to patients lack of response the balance will be transferred to patient responsibility immediately and you will be billed accordingly. Necessary action will be taken to collect balances due to the practice.

4. USUAL AND CUSTOMARY RATES: Our practice is committed to the best treatment for our patients and we charge what is usual and customary for our area. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under Medicare program and/or other medical insurance. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

5. MISSED APPOINTMENTS: Unless canceled, at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

WE ARE HERE TO HELP!

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 the terms of this Financial Policy.

Signature

Date