
INFORMATION ABOUT OUR PRACTICE

APPOINTMENTS

Appointments can be scheduled by calling the office between 8:30 a.m. and 4:30 p.m. on Monday through Thursday and 8:30 a.m. to 2:30 p.m. on Friday

Please be on time for all appointments and let us know if you are unable to keep an appointment. If you are unable to come in, please call 24 hours in advance. Patients who do not show up, or do not cancel within 24 hours may be charged for that visit. Most appointments take approximately 1 to 2 hours.

WHAT TO WEAR

In general, it is advisable to bring gym shorts, t-shirts, jogging pants, sneakers, etc.

INSURANCE AND FEES

Patients subscribe to a variety of insurance plans with different payment and reimbursement schedules. Make sure you read your plan and understand the coverage. This is your responsibility. Our office will assist you in every way possible and submit your claim when appropriate.

Please acknowledge that you were informed your benefits are: _____ and that this information is based on information received from your insurance company and may not be 100% accurate. You are responsible for verifying these benefits with your insurance company. Your balance cannot be verified until processed and returned from your carrier for accuracy and you will be responsible for the balance the carrier deems your responsibility.

Please acknowledge by initialing here: _____

We are providers for some area HMO's and will bill directly to the carrier in those cases. In instances where we cannot bill directly, it is your responsibility to pay us and seek reimbursement from your carrier. Our policy calls for payment at the time services are rendered. Special plans can be worked out in cases of true financial hardship. In the event of non-payment when due, your account may be assigned by us to a collection agency or an attorney. Checks returned to us for insufficient funds will be charged a \$20.00 fee.

RELEASE

I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I acknowledge that interest or a fee, at the provider's current rate, may be charged on all balances owing to the provider that are past due. I permit a copy of this release to be used in place of the original.

I fully understand and agree to the procedures and practices described above.

Signed _____

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