FINANCIAL POLICY AND MEDICAL RELEASE FOR PATIENTS WITH COMPENSATION, NO FAULT OR PARTICIPATING INSURANCE

All services will be billed to responsible insurance companies. If for any reason the claim is rejected, you will be responsible for payment. On past due accounts, a monthly billing fee may be added.

Any required co-payment is due on the day of the visit. There is a $5.00 fee for co-payments not paid at the time of service.

After the insurance payment is received, any deductibles that are the patient's responsibility are due immediately upon receipt of a bill.

There is a $40.00 fee for appointments that are not cancelled prior to 24 hours of a scheduled appointment.

There will be a $10.00 service charge for insurance forms that require someone in our office to complete.

The parent who brings the child for care is responsible for payment regardless of personal circumstances.

I further give authorization to release and obtain any information pertinent to my case.

I authorize payment directly to the HIGHGATE MEDICAL GROUP, P.C. for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.

I have read, and will cooperate with this financial policy.

Signed: ______________________________

Dated: ______________________________

Witness: ______________________________