Financial and Office Policies

(Initial each line)

- All professional services rendered by Med Center South, PC are charged to the patient. We will gladly file a limit of two insurances for you. However, patients are responsible for all fees regardless of insurance coverage.

- All co-pays, deductibles and non-covered charges are due at the time of service, regardless of who brings the patient in for his/her visit. We take cash, checks, Visa, MC, Discover and AMEX for your convenience.

- **Effective March 10, 2009, all patients without insurance will be charged $125 per office visit. If the physician requires a recheck within a week and no new symptoms have occurred, the office visit will be $65 per office recheck. Any additional services rendered will be billed separately to the patient for each visit. (Please note, that procedure charges are more expensive than the $125 office visit. Therefore the $125 that is paid date of service will be applied toward the total procedure charges.)**

- Most insurances do not pay for everything. Some services will not be covered and is the responsibility of the patient.

- It is the patient's responsibility to know your insurance benefits and whether the physician you see here is or is not a preferred provider.

- In order to release medical records, we must have a release signed by a parent or guardian on file.

- Effective July 1, 2007, there will be a $5 fee for all itemized statements or $10 per family.

- There is a fee and a 48 hour waiting period on all medical forms, blue cards not associated with a check-up and medical record copying. Please check with the office staff in advance on the cost for each request.

- There is a $30.00 fee on any returned checks.

- Any send out lab work will be billed from the reference lab that performs the testing.

Agreement To Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, Med Center South, PC has provided or will provide myself or my dependent with professional services and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and of my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand that any expense incurred by MedCenter South, PC in its effort to collect claims will be added to my bill and become my responsibility.

When you pay by check, you expressly authorize this merchant or its agents, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee not to exceed the state maximum legal limit.

I hereby authorize the physicians of Med Center South, PC to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

______________________________ ___________________________ ________________

Signature Relationship to Patient Date