

**Timothy A. Leach M.D.**

**Robert B. Cole, M.D.**

A professional corporation

**FINANCIAL POLICY**

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policy. If you have any questions please speak to Jamie our manager and biller. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

**FULL PAYMENT IS DUE AT TIME OF SERVICE**, unless other arrangements have been made in advance by either yourself or your health coverage carrier (medical insurance). For your convenience we do accept MasterCard, Visa, American Express and Discover.

**YOUR MEDICAL INSURANCE:**

If you do not bring us sufficient information to bill your insurance (i.e. Name, address, phone # of insurance company, medical group if relevant, ID and group ID's; name and date of birth of insured), then full payment is due at time of service.

**IT IS THE POLICY OF OUR OFFICE TO COLLECT ANY COPAYMENTS WHEN YOU ARRIVE FOR YOUR APPOINTMENT. WE DO REQUIRE A 72-HOUR NOTICE FOR CANCELLATIONS. WE WILL BILL A \$25 FEE TO PATIENTS WHO DO NOT CANCEL WITHIN 72 HOURS OF APPOINTMENT TIME.**

We hold contracts with many insurers and health plans. We will bill those plans with which we have a contract, and will only require you to pay the authorized co-payment at time of service. If your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If we determine prior to your visit that a service is "not covered", full payment is due at time of service.

We will only release the minimum amount of personal information necessary to get your claim processed.

If you have insurance with a plan with which we do not have a contract, we will be happy to prepare and send a claim for you on an unassigned basis. This means that your insurer will probably send payment directly to you. Payment is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility, and is due upon receipt of a statement from our office.

**MINOR PATIENTS:**

For all services rendered to minor patients, we will look to an adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

**Signature of Patient/ Responsible Party (if minor)** \_\_\_\_\_

**Please Print Name of the Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_