SUFFOLK SURGICAL ASSOCIATES, PC
STATEMENT OF FINANCIAL POLICY

Kindly initial each item as you read and understand it. Please feel free to ask us if you have any questions.

_____**SUFFOLK SURGICAL ASSOCIATES PC** is a provider for many insurance plans and we will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. However, to avoid any confusion, be aware that we **do** expect payment of any applicable deductibles, co-payments or co-insurance at the time of service. Also, any services that your insurance will not cover are your responsibility.

_____**If you have HMO insurance, it requires authorization** for any of your services in the office or if the Doctor refers you elsewhere. If this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred, and will be required to sign a financial waiver.

_____**If we are not a participating provider** for your insurance plan, we will bill your insurance directly if you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying. You may wait to pay us until after the insurance has paid its portion providing the insurance company pays within 30 days.

_____**If you do not have insurance**, payment is expected at the time of service. For your convenience we accept Visa, MasterCard, Discover Card and debit cards. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

_____**If you need our doctor to complete forms such as disability or Department of Motor Vehicles, there will be a $10.00 fee per page per form to be completed.**

_____**Statements are mailed monthly** to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the Business Office at (631)665-8200 to make payment arrangements. Interest charges in the amount of 1.5% per month may be applied to any past due account.

_____A $20.00 Billing processing charge will be applied to any statements that are generated due to nonpayment of a copayment at the time of visit.

____**A 24, 48 or 72 hour advanced notice is required if you must cancel or change your appointment.**
If you are new to our practice and miss your initial appointment without notifying our office, all future appointments must be guaranteed with a credit card. Missed Office appointments without the required 24 hour notice will result in a missed appointment charge of $25.00; Missed Sonogram or Office Procedure appointments without the required 48 hour notice will result in a missed appointment charge of $50.00; missed or cancelled Hospital based surgical /procedures without the required 72 hour notice will result in a missed appointment charge of $100.00. **Our policies are created to allow for effective scheduling and to ensure all patients wishing to be seen or treated may be accommodated. Please help us better serve you by notifying us as soon as possible if you must change or cancel your appointment.**

____**I hereby authorize Suffolk Surgical Associates, PC** to furnish information to my insurance carrier concerning my illness and treatment. I hereby assign to the physician all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance. If additional statements are required due to excessive lateness will be liable for monthly finance charges. This information my be disclosed to any other healthcare facility that is or will be involved in my care and treatment for the purpose of providing health care services to me.

____**I am aware this office may use any alternate telephone** number(s) that I have listed, and others may become aware of any medical conditions.

I FULLY UNDERSTAND THE ABOVE STATEMENT ANDY ANY QUESTIONS HAVE BEEN EXPLAINED AND ANSWERED FULLY BY THE OFFICE STAFF.

PATIENT SIGNATUARE:_____**DATE:**_____

GUARDIAN/SPOUSE SIGNATURE:_____**DATE:**_____

STAFF MEMBER/TITLE:_____ **DATE:**_____

(10/2013-REVISED ptstatementfinancialpolicy)