



Patient: _____

BILLING & PAYMENT POLICY

TO OUR PATIENTS:

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Please understand that payment of your bill allows us to continue to provide our patients with quality treatment and care. To help answer questions you might have, we have outlined our payment policies below. Please feel free to discuss these policies with us at any time should you have additional questions. Our accounts receivable representative will assist you in all of your billing needs.

HEALTH INSURANCE:

Insurance policies are a contract between you and your insurance company. You, not your insurance company, are ultimately responsible for payment of your account. It is very important that you know how your insurance works. We will assist you in any way possible in obtaining your insurance reimbursement.

Reese Surgical Group is a participating provider for most insurance plans. We will call to verify your insurance plan and obtain a "quote on benefits", although this will not guarantee payment.

If you have a CO-PAY, you are required by your insurance company to pay it at the time of service. All other patient responsibilities (co-insurance/deductible/denials) will be billed to you once we receive an explanation of benefits from your insurance company stating what you owe. We send out monthly statements on all accounts, these are due within fifteen days of receipt.

- If your account is excessively overdue it may be sent to an outside collection agency.
- A finance charge of 1.8% per month (21.6% annual percentage rate) will be added to any balance not paid within 91 days. Past due accounts may be turned over to an outside collection agency.
- A \$25 fee will be applied for NSF checks returned by your bank.
- We accept cash, check, and all major credit cards.
- We understand that financial problems do arise from time to time. Let us know if you need to arrange a reasonable payment program that will help resolve your balance.

I have read and agree to the payment terms listed above.

Signature/Date

Witness

Print Name