Robert A Davis, MD Family Practice
FINANCIAL POLICY

PATIENT'S PRINTED NAME: _____

Thank you for choosing as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

- **All patients must complete our Information and Insurance forms before seeing the doctor.**
- **FULL PAYMENT OF PATIENT RESPONSIBILITY IS DUE AT TIME OF SERVICE.**
- **Insurance cards must be presented at every visit.**
- **Not having your insurance card or rebilling for incorrect insurance information will cost you $15**
- **If you have a copay, you are responsible for paying at time of visit.**
- **You are responsible for paying your bill within 30 days of receipt.**
- **Bills not paid within 30 days, we will add 10% for every 30 days missed for untimely payment.**
- **Bills that are sent to collection will cost you an additional $50**
- **Completion of forms, disability, life insurance, school or physical forms will cost $15**
- **All copays, deductibles, and payment of non-covered services are due prior to treatment.**
- **We accept cash, checks, credit and debit cards.**

If your insurance company has not paid your account in full within 31 days, the balance will be automatically be transferred to you.

Participating
Please be aware that some, and perhaps all, of the services provided may be non-covered services. It is our policy not to perform those services unless deemed medically necessary.

Medical Record Request
We use an outside copying service to complete request for medical records, you must fill out a request to have your medical records copied and sent. Request are picked up by the service on Mondays and the service bills you for the any fees incurred to copy and send your records.

Missed Appointments

Unless canceled 24 hours in advance, unless the cancellation was for an emergency, i.e. hospitalization. Our policy is to charge for missed appointments at the rate of $ 40 per single missed appointment. Please help us serve you better by keeping scheduled appointments.

- I acknowledge full responsibility for services rendered by Robert A. Davis, MD Family Practice.
- I understand that payment of charges incurred is due at time of service unless other financial arrangements have been made prior to treatment.
- I further authorize and request that payments be made directly to Dublin Medical Center or Robert A Davis, MD.
- I consent to the release of my health information by Dublin Medical or Robert A. Davis, MD for the purpose of obtaining authorization and payment of services. Your consent does not waive your rights under HIPAA.
- I have read the Financial Policy, understand it, and agree to the terms of this Financial Policy.

Patients Signature: _____ **Date:** _____

Date Of Birth : _____