

**C. VINCENT PHILLIPS, M.D.**  
**JOHN BUXTON, M.D.**  
**JAVIER MIRO, M.D.**  
**FARZIN SHARIATMADARI, M.D.**  
**MICHEL MICHAEL, M.D.**  
**EDWARD TAYLOR, M.D.**  
**GREGORY WILLIAMS, M.D.**

## **OUR FINANCIAL POLICY**

Thank you for choosing us 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 to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

- CO-PAYS, DEDUCTIBLES AND PERCENT OF NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD OR DISCOVER CARD..
- COPY OF DRIVER'S LICENSE (FOR I.D. PURPOSES) COPY OF INSURANCE CARD(S)

### **Regarding Insurance:**

We may accept assignment of insurance benefits. However, we do require the above to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

### **Cancellation or Rescheduling Surgery:**

There will be a charge of \$100.00 for all surgeries that are cancelled or rescheduled with less than five business days notice.

### **Usual and Customary Rates:**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

### **Medicare Assignment:**

#### **If you have medicare please sign the following:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to C. VINCENT PHILLIPS, M.D., JOHN A BUXTON, M.D., JAVIER MIRO, M.D., EDWARD TAYLOR, M.D., MICHEL MICHAEL, M.D., FARZIN SHARIATMADARI, M.D. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Consent to release information:**

I hereby authorize C. VINCENT PHILLIPS, M.D., JOHN A BUXTON, M.D., JAVIER MIRO, M.D., EDWARD TAYLOR, M.D., MICHEL MICHAEL, M.D., FARZIN SHARIATMADARI, M.D. and GREGORY WILLIAMS, M.D. to furnish information to any referring physician, agency, or insurance company (ies) I have listed on the Patient Information form.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I have read the Financial Policy. I understand and agree to this Financial Policy.**

X \_\_\_\_\_ Date \_\_\_\_\_  
*Signature of Patient or Responsible Party*

X \_\_\_\_\_ Date \_\_\_\_\_  
*Signature for Co-Responsible Party*

**Minor Patients Or Signature Is Someone Other Than The Patient:**

The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment. Minors must be accompanied on first visit by parent or responsible party to establish financial responsibility. If signing for the patient please write in the patient's name followed by your signature.

Name of signing party, print: \_\_\_\_\_ Signature: \_\_\_\_\_

Address of signing party: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Reason patient could not sign. \_\_\_\_\_

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.