

Jeffrey P. Snow, M.D., P.A.

General & Laparoscopic Surgery
Diplomat of the American Board Of Surgery
Diplomat of the American Board of Colon and Rectal Surgery

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 bills 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 Form before seeing the doctor, Copayments, coinsurance and deductibles are due at the time of service. We only accept cash or Visa, Master card, Discover, or American Express. **We do NOT accept checks.**

Should the account not be paid, the patient assumes all cost of collection, including, but not limited to court costs, interest and legal fees.

REGARDING INSURANCE

We will accept assignment of insurance benefits; however we do require a percentage of the bill to be paid at or before the time of service when applicable. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you provide us with complete and accurate date. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We will facilitate the claims process by filing for you. If your insurance company has not paid your account in full within 45 days you will be responsible for the balance. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and other medical insurance.

Exceptions to the above policy are restricted to the plans for which Dr. Snow is a contracted provider (e.g. certain HMO's & PPO's). You will be responsible for all required co-payments and deductibles at the time of service. You will also be responsible for payments for procedures not covered by your insurance company, or procedures performed for pre-existing conditions if not covered by your policy. We will assist with obtaining authorizations for all procedures; however, pre-authorizations are not a guarantee of payment by your insurance company.

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

MISSES APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of normal office visits. Please help us serve you better by keeping scheduled appointment.

SURGERY

A **\$100.00** cancellation fee may be applied if surgery is cancelled within 72 hours of the procedure.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and understand and agree to this Financial Policy.

Signature of patient or responsible party

Date