FASV, P.C.
FINANCIAL POLICY

Thank you for choosing **FASV, P.C.** as your healthcare provider. We are committed to providing quality treatment. 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 this information before seeing the doctor.

Regarding Insurance

We may accept assignment of insurance benefits. However, we require all co-payments to be made at time of service. The balance is your responsibility whether or not your insurance pays. We cannot bill your insurance company unless You give us current insurance information and a current insurance card to copy and keep on file. Your insurance policy is a contract between you and insurance company. We are not 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. You will be responsible for these balances.

Initial_____

Returned Checks

There will be a $50.00 returned check fee on all returned checks. In the event that a check is returned for insufficient Funds, we will call your bank to verity funds for any future checks that are presented for payment on your account.

Initial_____

Collection Fees

In the event that your account is turned over to a collection agency, you will be responsible for all collection cost Including attorney's fees and collection agency fees.

Initial_____

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per missed appointment. Please help us to serve you better by keeping scheduled appointments.

Initial_____

Fees for Letters and Forms

Your health care provider will be more than happy to complete the medical portions of any necessary form(s) you may need. Please be advised that there is fee of $15.00 per form, due to the time required to dictate and complete letters and forms. These costs are considered non-covered by the insurance companies and are the responsibility of the patient. A fee schedule is available upon request and payment is to be made upon completion.

Initial_____

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

X_____ Date:_____

Signature of Patient or Responsible Party

For you convenience, we accept cash, check, credit cards (visa, master card), and debit cards