

Synergy Release Sports
Dr. Hatrak, Dr. Zoeller, Dr. Malucci, Dr. Marchman

OFFICE FINANCIAL POLICY

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity and expertise required of the care rendered to you. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Our policy requires payment at time of service unless specific arrangements have been made in advance. Our agreement is with you and not your insurance company. Although we will assist you in submitting your claims to our insurance company you are financially responsible for services you receive. Payment to our office is not contingent upon payment by your insurance company. You are considered a cash patient until you provide completed insurance information, and we verify and accept your insurance coverage.

If you wish to file your own insurance claims we will provide you with the necessary itemized statements to file for reimbursement.

If you request that we file your insurance claims for you and if we agree to accept assignment from your insurance company, and if your carrier has not paid a claim within thirty (30) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within sixty (60) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

HMO and PPO members will be expected to pay co-pays or deductibles at the time of service.

Blue Cross Blue Shield members will be expected to pay charges in full at the time of service. Blue Cross Blue Shield sends checks to the patient when the provider is out-of-network therefore you will keep any checks received by your insurance company.

When your schedule of visits is once per month or longer, you may not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered or by an authorized payment plan. We will continue to provide you with an insurance ready receipt. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

If you have pre-paid for any services and do not receive them or if you cancel any pre-paid services, you will receive a pro-rated refund following a complete resolution of any outstanding payments from your insurance company.

If a check is returned, there will be a \$35 service fee charged.

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1. ( ) I request this office to file insurance for me. OR

2. ( ) I will file my own insurance.

I have read and understand my financial responsibilities under this financial policy.

Guarantors Printed

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

For your convenience you may retain your credit/debit card number on file with us.

( ) MasterCard ( ) Visa

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Finance Counselor: \_\_\_\_\_ Date: \_\_\_\_\_