DAYONE FAMILY HEALTHCARE FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment.

It is the patient's responsibility to inform us of information changes of any kind. This allows us to better serve you by having all of your personal and insurance information on file and current.

OFFICE VISIT CO-PAYS ARE DUE AT THE TIME OF SERVICE. FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR UNINSURED AND ALL NON-CONTRACTED INSURANCE. A $10.00 BILLING FEE WILL BE APPLIED IF PAYMENT IS NOT MADE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS OR VISA/MASTERCARD.

There is a $40.00 dollar charge for any missed appointments or late cancellations. Please call our office if you are unable to keep your appointment so that we may reschedule the appointment for you. We do require a two hour notice for all reschedules and or cancellations. Your health is extremely important to us.

Regarding Indemnity Insurance
Your insurance policy is a contract between you and your insurance company. You are responsible for payment of 100% of our charges. As a courtesy, we may bill your insurance for minor office surgeries and hospital services. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under your medical plan. It is your responsibility to know your insurance coverage and benefits and to provide us with that information.

Regarding Insurance Plans Which We Are Contracted
Your office visit co-pay will be collected at the time of service. If your insurance does not have a straight dollar co-pay amount, please be prepared to pay the percentage due at check out. If your insurance has not responded to our claim within 45 days, you may be asked to contact them for payment.

Regarding Minor Patients
The adult accompanying a minor (parent or guardian of the minor) is responsible for full payment of co-pay and deductible amounts. If unaccompanied by an adult the co-pay will be collected from the minor. We do not become involved in Court ordered medical reimbursement. Payment is the responsibility of the accompanying adult or custodial parent.

Assignment of Benefits
I hereby assign payment of authorized Medicare and any other medical and/or surgical insurance company benefits, to include major medical benefits to which I am entitled, to be made either to me or on my behalf to Dr. Ptacin or Dr. Galonsky for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

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

X ________________________________ *Date Of Birth:*___________________ *Date* _________________
Patients Name Printed

X ________________________________ *Date* _________________
Witness

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of DayOne Family Healthcare's Notice of Privacy Practices.

X ________________________________ *Date* _________________
Patients Signature or Legal Guardian (if patients is a minor)