



Financial Policy

Patient: _____

Welcome to Dr. Jeffrey Masin's office. In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our financial policies.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. **We will collect your co-payment, deductible or charge for non-covered services at the time of your visit.** If you have a balance after an insurance payment from a previous service, we will ask for that payment. We accept cash, checks, money orders, Visa. Mastercard, Discover and Care Credit.
2. We require that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
3. If we do not participate with your insurance company, you will be expected to make full payment at the time the service is rendered.
4. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency that will report to the credit bureau. At that time we will charge you a **\$10 collection fee**.
5. If your plan requires a referral or authorization to see a specialist, you need to obtain that from your PCP prior to seeing Dr. Masin. No retroactive referrals can be obtained.
6. **No show or missed appointments**- We understand there may be times when you are unable to keep an appointment, but we need to get a phone call from you to cancel the appointment. If **three** appointments are missed, you will be dismissed from the practice for non-compliance.
7. Your insurance is a contract between you, your employer and the insurance company. **We are not a party to that contract.** It is very important that you understand the provisions of your policy. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.
8. You are authorizing us to release medical information to health care providers involved in your/your child's treatment, to state and federal regulatory authorities and to your insurance company as requested.

Remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have questions regarding our financial policy, contact our billing department at 330-379-9070.

We have verified your insurance information.

Deductible: _____

Out of Pocket Max: _____

Co-Insurance: _____

Co-Payment: _____

DEPOSIT AMOUNT: _____

I understand this is just an estimate and I will be responsible for any remaining balances after the insurance pays.

Signature: _____

Date: _____