

MICHAEL SUTPHIN, M.D.

FINANCIAL POLICY

We have provided the following financial policy which we need for you to read and sign prior to any treatment. All patients must complete our "Patient Information Form" before seeing the doctor.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. WE WILL THEN BILL YOUR INSURANCE IF REQUESTED. WE ACCEPT CHECKS, CASH, OR CREDIT CARDS. WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL. WE PARTICIPATE WITH MEDICARE, BLUE CROSS, AND MEDICAID OF WYOMING.

REGARDING INSURANCE:

The balance of your account is your responsibility whether your insurance company does or does not pay. Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. We cannot bill your insurance company unless you bring in all information. By asking this office to file your insurance claims for you, you agree that your insurance company may send payment for services directly to this office.

UCR (Usual & Customary)

The term "usual and customary" is a fantasy phrase used by insurance companies to justify low payments to physicians. Our practice is committed to providing the best treatment possible to our patients and we charge what is reasonable for our area. You are responsible for payment in full (or Medicare co-pay) regardless of any insurance company's arbitrary determination of "usual and customary" rates.

FINANCE CHARGES:

We do not add finance charges. So, please keep your account current. If it becomes necessary to assign your account to a collections agency, you will be held responsible for all collection agency costs and legal fees.

MISSED APPOINTMENT:

It is very important not to miss any appointment(s) if at all possible. Cancelled appointments affect the continuity of health care. If you must cancel an appointment, please do our office the courtesy of calling and canceling so that other patients may be put in your place and we will gladly reschedule you.

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

I, the undersigned, have read and understand the above stated financial policy. I agree to the terms set forth in such policy.

X _____
Signature (Patient or Responsible Party)

Date _____