JOANNE S. HINSON MD.

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FINANCIAL POLICY AND AGREEMENT

Thank you for choosing me as your health care provider. I am committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing me as a provider.

1. Each patient is responsible for her own bill.
2. Payment of all insurance co-payments and deductibles are required at the time medical services are rendered. A billing fee $10 will be charged if you are unable to pay required co-payments on the day of service.
3. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks, and major credit cards.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.
6. If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay.
7. Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1 ¾% per month (21% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of $.50 per month. By signing below, you agree to pay collection costs up to 40% with or without suit and/or reasonable attorney fees on any delinquent balance, if referred to any agency or attorney for collection or suit.
8. A $25.00 fee will be charged on all returned checks.
9. Patients who fail to appear for their scheduled appointments may be charged a fee of $50, unless the patient cancels the appointment at least 24 hours before the scheduled appointment time

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your instance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

AUTHORIZATION TO PAY BENEFITS

I further authorize and direct said agency, attorney or insurance company to pay from the prceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

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