

Gary J. Price, M.D., P.C.

Dear Patient:

Thank you for choosing our office for your medical care.

In the present climate of healthcare reform, our office is making every effort to keep medical costs down for our patients. In order for us to successfully do this, we ask for the cooperation of our patients; please read the Financial Policy carefully. Our main concern is to provide you with good care in a convenient, informative and helpful manner. If you have any concerns about our payment policies, please do not hesitate to ask our office staff.

Payment for office visits (as well as copayment, if it applies) and any in-office surgical procedures are due at the time of service is rendered unless:

1. The doctor participates in your health plan.
1. Your health plan covers these services.
2. Special arrangements are made in advance.

Payments related to cosmetic surgery must be paid in full **Two weeks prior** to the scheduled surgery.

We accept cash, check, Mastercard, or Visa. Return checks will be subject to a **return check fee of \$25.00.**

Charges are the responsibility of the patient or the responsible party. Please remember your insurance policy is a contract between you and your insurance company.

Not all services are a covered benefit in all insurance contracts. We can assist you with your inquiry to your insurance company as to your eligibility for benefits. **If we do not participate with your insurance, you will be responsible for the difference your insurance company does not pay.**

If the insurance company does not pay your balance in full within **45 days**, we ask that you contact the carrier to help speed things up. If the insurance company does not pay the full amount within **60 days**, we will expect that you make payment on any balance that is due. Balance more than 90 days overdue will be subject to a **1½ % finance charge.**

Finally, we understand that temporary financial considerations may affect timely payment of your balance. We encourage you to communicate any difficulty so that we can assist you in making arrangements for payment schedule. We hope that these efforts are helpful and informative. We are grateful for the opportunity to serve you and appreciate your trust in us.

Date:

Signature of Patient or Responsible Party

Authorization for Disclosure of Information

I Authorize Gary J. Price, M.D. to disclose complete information concerning his medical findings and treatment to the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Gary J. Price, M.D. sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Date:

Signature of Patient or Responsible Party

Date:

Witness