

JON B. BISHOP, M.D.
FINANCIAL POLICY

We are committed to provide you with the best possible medical care. Your understanding of our Financial Policy is important to our professional relationship. Please ask a staff member if you have any questions regarding our fees, Financial Policy, or your responsibility.

Our office is filing insurance claims with an increasing number of insurance companies; therefore, it is impossible for us to keep a record of your personal insurance coverage. **Please read your insurance contract to understand the benefits available to you.**

Industrial Insurance:

If your injury occurred at work, **Your Regular Health Insurance Will Not Pay** any claims. If you wish your **Industrial Insurance** to pay for any office visits, tests, or surgery, **YOU** are responsible to provide your claim number, the adjuster's name, and us with the name of the Industrial Insurance to be billed. **YOU** are also responsible to make certain your employer files the proper papers with the industrial carrier and the carrier pays those claims. If your case is being disputed with your industrial company, **YOU** are required to make payment in full and then seek reimbursement once your case is settled.

Insurance Cards:

I understand that when I come to an appointment without my insurance cards I will be responsible for any denied or penalized payment incurred due to misinformation supplied by me. It is my responsibility to see that everything is correct and the doctor rendering services will not write off any penalty.

Referral Forms:

Many insurance companies require patients to bring a referral form from their Primary Care Physician at the time of our service. Any charges not paid by your insurance company because we had no referral to submit, will be **YOUR** responsibility.

Insurance Card:

If you do not have your insurance card or proof of insurance, **YOU** are expected to pay for your visit at the time of service. **ANY CO-PAYMENT NOT PAID ON THE DAY OF YOUR APPOINTMENT WILL HAVE A \$20.00 CHARGE ADDED ON TO THE PAYMENT TOTAL. ANY RETURNED CHECKS WILL INCURE A \$30 FEE.**

Co-Payments:

If your insurance company requires a co-payment, **YOU** are expected to make this payment at the time of service.

Pre-Authorizations:

Many insurance companies are requiring pre-authorization on surgery and special procedures. **WE** will pre-authorize your surgery with your insurance company. Pre-authorization is not a guarantee of benefits.

Litigation:

If you have a case in litigation, **WE** require that fees are paid at the time of your visit and **YOU** seek reimbursement when your case is settled.

Terms:

Net 60 days. A financial charge of 1.5% per month (18% annual percentage rate) will be applied to any amount paid after 90 days.

I certify that the above information is correct and authorize my insurance company and/or **Jon B. Bishop, M.D.** to secure or release any information relating to this claim. I understand that I am fully responsible for this bill. In the event of non-payment of the bill, I agree to pay additional costs of attorney fees, interest, and reasonable court costs. I authorize insurance benefits to be directly paid to **Jon B. Bishop, M.D.**

I agree that my copy of this authorization shall be as valid as the original.

Patient (parent/guardian, if a patient is a minor) must sign here

Date