CORNERSTONE MEDICAL
Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Insured Patients

□□Copays, Co-Insurance and Deductibles are due at the time of service. For your convenience, we accept cash, Check, and most major credit cards.

□□In the event that your insurance carrier determines a service to be "non-covered", you will be responsible for the complete charge(s).

Non-Insured Patients

□□Non-Insured patients will be required for an office visit prior to being seen. There may be additional charge(s) depending upon the procedure(s) performed. Payment for additional services is due prior to leaving the office. Please see the billing staff if you have any questions.

All Patients

□ Returned Checks: A $25.00 fee will apply to all checks returned to our office as "unpaid". Payment for future services may be required by cash or credit card.

□ Medical Records: A fee may be charged for providing copies of medical records. Please inquire with the Office Manager.

❒FMLA Forms: A fee of $25.00 will be charged for completion of forms. Payment is due at the time the completed form is picked up.

❒Please take note of your EOB (Explanation of Benefits) form that you receive from your insurance carrier. Your EOB will serve as your statement and your balance due to this practice will be noted on the EOB form and payment will be expected within 30 days from the date you receive your EOB.

❒ I have read and fully understand the policies of this office regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I understand that I am responsible for following my insurance plan's regulations, policies and procedures.

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Signature of Patient/Guarantor **Date**

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