DOB: _____

PCCS/NSDC
PATIENT PAYMENT POLICY 2017-2018

Dear patient:

It is the **POLICY** of the practice not to release patients of their financial obligations set forth by your agreement with your insurance provider.

Your insurance coverage is between you and your insurance company. It is impossible for the practice to know the details of every health plan. **It is your *responsibility* to know *your* policy and verify your coverage for services.** If your plan requires a referral prior to treatment, then it is *your responsibility* to obtain it from your primary care physician. ***If you do not have a referral at the time of your visit and your plan requires one, your appointment will be rescheduled.***

Our policy is to collect all pre-determined co-pays and all unpaid balances at the time of check-in. Please be prepared to make these payments. If you are responsible for a deductible or a co-insurance you may be required to pay 50% of the bill amount. This percent will be determined at check out. **NOTE: YOUR** agreement with your plan requires that you pay the required fees and **OUR** agreement with your plan requires that we will comply with plans contract.

We ACCEPT cash, check, and Visa/MasterCard for payments. If you have ever provided us with a non-sufficient fun check, future payments will only accept cash or credit for further future services. If you present to a visit without the means to pay for your portion, we will re-schedule your visit for another date when you are able to pay.

Completions of forms will be *assessed* to a $20 processing fee. Failure to arrive for your scheduled appointments or testing's, **without a 24- hour notice to the practice will result in a "No-Show" fee to your account $50.00 for office visits $250.00 for sleep diagnostic testing.** Unfortunately it has become necessary due to the frequent numbers of 'Failures to no-show". **We PREFER that you keep your schedule appointments.**

We appreciate your time and attention to our policy. If you have any questions or concerns please contact the billing department at 248-449-7010 extension 216.

Financial Responsibility:
I have read and understand the payment and policy of PCCS/NSDC and its contractual obligation to my chosen insurance provider. I understand that I am responsible to pay for the services rendered, at the time of service, including all responsible attorney fees and cost of collections in the event of default.

_____ _____ _____

PATIENT/ GUARANTOR NAME (PRINT) **PATIENT/ GUARANTOR SIGNATURE** **DATE**

RECEIVED BY: _____ DATE: _____