ORCHARD PARK FAMILY PRACTICE, PC
3670 S. BENZING ROAD ~ ORCHARD PARK ~ NEW YORK ~ 14127
(716) 662-5357 ~ FAX (716) 662-2774

OFFICE POLICY

We at Orchard Park Family Practice are committed to providing you with the best possible care and would be happy to discuss our policy with you at any time. Your clear understanding of our Financial Policy is important to our Professional Relationship. Please ask if you have any questions regarding our fees, financial policy or your financial responsibility.

Canceled, Re-scheduled, and No-Show appointments:
The patient is required to notify our office at least **24 hours in advance** of an appointment they wish to cancel or reschedule or it is considered as a **NO SHOW**. If the patient is 15 minutes late for their appointment, it is considered a **NO SHOW** and they will be required to reschedule. If the patient **NO SHOWS** for an (1) appointment the patient will be billed a $25 fee. A subsequent (2nd) **NO SHOW** appointment in 12 months will be billed $50. A third **NO SHOW** appointment in 12 months will be billed $75. A patient will be reviewed for release from our practice for failing not to show for appointments.

***Patient Forms*:**
The patient will be required to pay a **$20.00 fee for any forms** that are required to be completed. (disability, FMLA etc)

Worker's Compensation:
As of April 1, 2011 our office no longer accepts worker's compensation cases, new or old. If you are seen for an illness or injury that is worker's compensation related **you will be responsible for payment of services** as these charges cannot be billed to your insurance.

Insurance Participation and Financial Responsibility:
It is the patient's responsibility to be aware of their insurance coverage, policy provisions, authorization requirements as well as network providers if applicable.
Insurance information must be **given to us within 30 days of the date of service**, as we only have a certain time frame to submit a claim to your insurance on your behalf. We will bill insurance companies as a courtesy to you. If we have not received payment from an insurance company within 60 days of the date of service, you will be expected to pay the balance. We provide you with all necessary information to submit your claim to your insurance company. We will not become involved in any disputes between you and your insurance company re: deductibles, co-payment, secondary or tertiary insurances, co-insurance, covered charges etc. other than to supply them with necessary factual information.

Payment Due at Time of Service:
Insurance **co-payments are to be made at EACH visit**. Failure to do so will result in an additional $5 surcharge. Our practice accepts cash, personal check, Discover, MasterCard, American Express and Visa. There is a service charge of $15 for returned checks. The office does give patients with no insurance a 20% discount **only** if the balance is paid at the time of service. If you have a **high deductible insurance policy you are required to pay $50 at the time of service** for each appointment and we will bill you for the remaining balance, NO EXCEPTIONS.

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Office Policy cont.

Custodial Parent Responsibilities:
The custodial parent is responsible for payments at time of service whether the child has insurance or not. The office will not get involved with % breakdowns such as one parent being responsible for 20% and the other parent 80%. It is the parent's responsibility to work out an agreement for payment-in-full at time of service.

Assignment of Benefits and Consent for Treatment:
I hereby assign all medical benefits to include Major Medical benefits to which I am entitled, including Medicare, private insurance and any other plan to Orchard Park Family Practice, PC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize my physician to perform any medical treatment as deemed necessary.

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that, unless I maintain the agreed-upon payment agreement, my account may be turned over to a collection agency. If my balance should go to collections, I am aware that I will incur an added fee of up to $50.00 to cover the collection companies fee.