

Financial and Administrative Policy

Ernesto C Torres, M.D.

Insurance:

Insurance is a contract between you and your insurance company. We will not become involved in any dispute between you and your insurance company regarding deductibles, copays, covered charges, secondary insurance, etc., but will be happy to supply any information needed to pay the claim. If the insurance payment has not been received after sixty days, the patient will be responsible for payment.

Copays and Deductibles:

All copays and deductibles are due at the time of service unless a payment plan has been established prior to the visit. An insurance claim will be submitted to your carrier and there may be residual amounts billed to you after your insurance has processed the claim.

Finance Charges:

There will be a \$10.00 billing fee attached each month to any account not paid within thirty days. Our Billing Department will work with you to resolve any outstanding balances.

Missed Appointments:

There will be a \$35.00 charge for missed appointments and appointments not cancelled 24 hours in advance.

Forms and Records:

There is a \$5.00 fee to complete forms and we request one week for completion. There is a \$20.00 fee to copy records for transfer and we request 10 days to prepare the records. Forms and records will be available for pick or we will mail them if provided with a self-addressed stamped envelope.

Prescription Refills:

You may leave your prescription refill requests 24/7 on our refill line. Prescriptions will be phoned to the pharmacy within the next 24 hours during our work week. Please remember ADD medications cannot be phoned, they must be picked up. Prescriptions will not be filled if appropriate follow up appointments are not kept.

I authorize the release of any information relating to all claims for benefits submitted on behalf of my dependent/ dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, without obtaining my signature on every claim.

I understand I am financially responsible for all charges incurred and I agree to accept all financial responsibility for those charges.

Signature: _____ Date: _____

Relation to Patient: _____