GERIG SURGICAL ASSOCIATES, P.C.

2006 South Main Street, Suite A, Goshen, IN 46526
Phone: 574.535.9100 Fax: 574.535.1020

Financial Policy

We are committed to providing you with the best possible medical care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Please advise us when registering if you have special financial needs that we can address with you before your appointment.

It is your responsibility to:

- Inform our office of your **current insurance** and present your card(s). If we do not receive the proper insurance information from you, you will be billed and responsible for any charges incurred until we receive this information.
- Obtain any necessary **referral** required by your insurance from your Primary Care Physician **prior** to your office visit. If it is not obtained, your visit may be rescheduled.
- Remit payment for medical care not covered by your insurance (deductible, copays, non-covered services, etc.) at the time of service. Payment may be made by cash, check, Visa or MasterCard.
- Notify us if your visit is to be covered by **Workman's Compensation**. It is your responsibility to obtain authorization for the consultation before your visit.

If we do not participate in your insurance plan, our office is happy to file the claim on your behalf, however; payment in full is expected from you within 30 days unless special financial arrangements have been made with our patient accounts department.

For patients 17 years or younger, a parent or guardian **MUST** accompany them for all appointments (exception: emancipated minors) It is the parent or guardian bringing the minor that is responsible to provide us with the necessary referrals and insurance cards as well as to make any payment due at the time of service.

Our charges are determined by what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of rates.

Specific coverage issues should be directed to your insurance plan's customer service department, and that information is usually found on the back of your insurance card.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication.

You agree, in order for us to service our accounts or collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contacts may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that Lender/Creditor may contact me as described above.

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Signature of Patient or Responsible Party Date