



The Bariatric & Metabolic
WEIGHT LOSS CENTER

OUR FINANCIAL POLICY

Thank you for seeking health care services from The Bariatric & Metabolic Weight Loss Center. Our highest priority is to provide you and your family with quality health care. Covering the cost of that care continues to be a challenge for patients, employers, and providers. Since payment for health care services has become increasingly complex, we find it helpful to have a policy to guide us all. Please review our policy and sign a copy for our records. If you have any questions, please ask.

CANCELLATION and NO-SHOW POLICY: Once an appointment is scheduled, you are expected to attend, unless you provide a 24-hour advance notice to avoid a missed appointment charge. **A fee of \$25.00 will be charged for an appointment that is cancelled with less than 24-hour notice and a fee of \$35.00 if you do not show to your appointment.** You are responsible for the appointments you schedule. This fee will be expected to be paid within 7 days.

Payment For Services

If you have Insurance coverage: We will file a claim to your insurer requesting that they reimburse us for the services, you received. You need only to pay your co-pay, co-insurance, and or deductible (if any) **at the time of service.** (As required by many plans, your co-pay may be collected when you check-in.) You will then be responsible for any balance unpaid by your insurer. If your insurer mistakenly sends reimbursement for our services to you, we ask that you promptly forward those funds to us to cover the services you received. **We must see proof of your insurance at each visit.**

If you have Insurance coverage in which our practice does not participate, we will file a claim to your insurer as a courtesy to you, but you are ultimately responsible for payment of the services rendered to you.

If you have no Insurance coverage you are obligated to make payment for **ALL** charges at the time of service.

If you are unable to make payments which you may owe, our Billing Office will assist you in making special payment arrangements, when possible.

For your convenience, we accept cash, checks, major credit cards (MasterCard, Visa, Discover, American Express), and debit cards. If you pay with cash, you should retain your receipt for your records.

Lab Fees : Any lab specimens we process will be billed by the practice. Any lab specimens processed at outside reference labs will be billed by those reference labs. (Your insurance company, if any, dictates

which reference lab we must use. If you do not update us of your current insurance coverage, your specimens may be sent to the incorrect lab, resulting in fees for which you will be responsible).

Referrals: Many managed care plans require "referrals" from your primary care physician to see specialists or perform tests. Many plans will hold you financially responsible if you receive services without following your protocols. **Please familiarize yourself with your plan.** We have staff and protocols in place to help you obtain any necessary referrals. If you require a referral, please ask for assistance. (You will be financially responsible for referrals we give you in error based on inaccurate or outdated Insurance information. It is very important that you keep us updated on your current insurance coverage and any changes).

Insurance Limitations: Each Insurance plan varies regarding whether a particular service is covered, and if so, to what degree and under what circumstances. Since you are financially responsible for any services you receive which your insurance company does not cover, it is very important that you familiarize yourself with your plan.

Acknowledgment of Receipt of Financial Policy I understand payment is expected when services are rendered. If my account becomes delinquent and requires submission to outside collection, I agree to pay any additional fees to cover collection costs, court costs, and attorney fees.

I have read, understand, and agree to adhere to the policies set forth above.

Signature: _____ Date: _____

Printed Name: _____

Acknowledgment of receipt of Privacy Notice

By signing this form, I acknowledge that I have received, read, and understand Piedmont Bariatric & Metabolic Weight loss center (a subsidiary of P.F.P.) Notice of Privacy Practices

Signature: _____ Date: _____

Printed Name: _____

Insurance Coverage & Authorizations I hereby authorize Piedmont Family Practice and its providers to apply for benefits on my behalf for covered services rendered. I certify that the information I have submitted is correct. I further authorize the release of any necessary information, including medical Information, to my insurance carrier. In the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration, a copy of their authorization may be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time in writing.

Signature: _____ Date: _____

Printed Name: _____