SIMON Family Medicine
YOUR FAMILY'S DOCTOR

PATIENT BILL OF RESPONSIBILITY

This office is committed to giving our patients the best care possible.
As a patient of Dr. Simon, I agree to the following:

I will make every attempt to understand the benefits of my insurance plan, even to the extent of calling my insurance carrier, to verify that Dr. Simon is a Participating Provider under my plan and to find out what services will and will not be covered. I also agree that if Dr. Simon or the procedures he performs are not covered by my insurance, I will accept responsibility of payment for services rendered.

___ If Dr. Simon refers me to see a specialist or to have further testing, I understand that it is ultimately my responsibility to determine that the provider is participating with my insurance carrier. Dr. Simon's office staff will do everything possible to insure that your referral covered by your insurance; however, please check with your insurance carrier BEFORE being seen by them. Dr. Simon's office will not be held responsible for you being seen by a provider that is not contracted with your insurance.

___ I understand that Dr. Simon's office will submit the charges incurred at this office to my insurance carrier. This is done as a courtesy to me. If after 90 days, from the date of service, my insurance carrier has not paid Simon Family Medicine, I will be held responsible for the balance of the bill. Ultimately it is my responsibility to make sure my insurance is paying in a timely manner.

___ I agree to pay all co-payments and/or deductibles that are due, at the time of service.

___ I understand that I am issued an account with a "Patient number", and that each time I am seen, a new "BILLING" is created under the patient number. A monthly "STATEMENT" is sent for all billings under my patient number that require a balance due. I also understand that if a bill on my account reaches over 30 days past due, a finance charge of 1.5% on the balance due can be assessed. If my account is sent to collection, I will incur a 30% collection fee.

___ If I do not have insurance coverage, I agree to the terms of the "Self Pay Policy".

___ Should my check be returned by my bank (e.g. insufficient funds), I agree to pay a $35.00 returned check fee.

___ If I fail to pay my bill in a satisfactory manner, and my account is assigned to an attorney for collection, I agree to pay the cost incurred, including attorney fees, whether or not a suit has been filed.

___ I understand that this office can only bill with the diagnosis documented in my medical chart. Thus, to ask to have a diagnosis changed for the purpose of securing insurance reimbursement is insurance fraud.

___ I agree to be on time for my appointment, or give at least 24 hour notice of my inability to make the appointment.

___ I understand that I will be billed $50 for missed appointments if I do not give at least 24 hour notice for cancellation or rescheduling.

___ If I miss more than two appointments without at least 24 hour notice I may be discharged from the practice.

___ I agree to reschedule my appointment if I am more than 10 minutes late.

___ I understand that if I have blood work done, Dr. Simon's office will contact me within a week to advise me of the results. An appointment may be needed to discuss the results.

___ I understand that Dr. Simon's office policy regarding returning phone messages and prescription refill requests, requires that I give at least two (2) business days for completion.

___ I understand that no profanity or verbal abuse will be tolerated toward the Doctor or his staff. This would be grounds for my discharge from the practice.

Patient or responsible party signature Date Witness