NEIL A. PATTERSON, MD PA

2984 Alafaya Trail
Suite 2000
Oviedo, Florida 32765

PATIENT FINANCIAL POLICY

Insurance Claims

As a courtesy, the Practice will file insurance claims with your insurance carrier. Your insurance company, in lieu of reimbursing you directly, will pay to the physician or Practice any benefits for services rendered. You are responsible for making available complete insurance information for accurate filing of claims. We will request your current insurance card at each visit. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. It is your responsibility to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts. Please call your insurance company to verify your benefits.

Scheduling Fees

If you are unable to keep your scheduled appointment, please contact our office at least 4 (four) office or business hours in advance. Failure to contact our office within the required timeframe will result in a $50.00 fee being applied to your account. This fee is payable by the patient and is not billed to your insurance.

Unpaid Account Balances

In the event that you fail to make payment for services rendered, any outstanding debt on your account may be turned over to a collection agency. You will be responsible to pay the collection agency fees (50% of total balance) and any other fees that may be incurred in the collection of any outstanding balance.

After Hours Service

Insurances will not pay for "*after hours*" services at this time. If new services are provided after regular office hours there will be a **$45.00 charge** for services rendered to you. This fee is payable by the patient or other responsible guardian and is not billable to your insurance plan. This fee will not be applied to your account if we have seen you for the same problem in the past week or if you follow-up with an office visit within the week for the same problem. If your urgent care facility co-pay is less that our charge for after hours care you may consider seeking care at an urgent care clinic.

I have read the above form and policies and agree to the terms stated.

Name (printed) _____

Signature patient / legal guardian: _____ Date: _____

Established pt. (10/2019)