

# STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Raynon A. Andrews, M.D., P.C.

The doctors and staff of Raynon A. Andrews M.D., P.C. appreciate the confidence you have shown in choosing them to provide for your health care needs. We are committed to providing you with the best possible medical care. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our services. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of services and care received under the care of Raynon A. Andrews, M.D., P.C..

## PAYMENTS

### Co-Payments Policy

1. All co-payments, co-insurance and deductibles are due and payable PRIOR to services being rendered and is required by your insurance to be paid at each visit.
2. If you do not know your co-pay we will collect a minimum fee of \$30.00. Our billing department will bill or credit you account accordingly after your insurance pays their portion. If you are not prepared or unable to pay your co-payment prior to your visit, we will kindly reschedule your appointment for a more convenient time
3. Overpayments will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 30 days of your verbal or written request.

### Returned Checks Policy

4. There is a \$15.00 service charge on all returned checks. After receiving a returned check, Raynon A. Andrews, M.D., P.C., will only accept cash, money order or credit card.

### Cancellation/No Show Policy

5. While understanding there may be times when you miss an appointment due to emergencies or obligations, Raynon A. Andrews, M.D., P.C. requires at least 24 hours notice on all cancelled appointments. Our office charges a fee of \$25.00 for appointments not cancelled or rescheduled 24 hours in advance.
6. Cancellation/no show fees must be paid prior to your next appointment.

### Form Completion Policy

7. There is a fee of \$10.00 for all completed forms. Multiple forms may be assessed a different fee. This fee is due upon pick up.

If you fail to meet financial obligations agreed upon in this financial policy or other payment arrangements made with Raynon A. Andrews, M.D., P.C., your outstanding balance will be sent to a collection agency and the complete balance will have to be paid before receiving any further treatment. Your future status with this office will be considered at that time and may lead to being discharged from Raynon A. Andrews, M.D., P.C. If you have any questions, please contact the billing department.

## INSURANCE

While the filing of insurance claim is a courtesy that we extend to our patients, it is your responsibility to:

1. Bring your insurance card to each visit
2. Notify our office of any changes to your insurance
3. Know your co-pay and be prepared to pay at each visit
4. Know your insurance company benefits and coverage
5. Determine if doctor(s) are network providers prior to first visit
6. Pay for any amounts not covered by your insurance

**I have read and understand Raynon A. Andrews, M.D., P.C.'s Statement of Patient Financial Responsibility. I agree to assign insurance benefits to Raynon A. Andrews, M.D., P.C. whenever necessary. I authorize Raynon A. Andrews, M.D., P.C. to release information to a collection agency or attorney. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Raynon A. Andrews, M.D., P.C. reserves the right to change or amend this statement at any time and at its discretion.**

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Signature of Patient/Responsible Party

Printed Name of Signer