

PETER C. BRASCH, M.D., LLC

1 Thurber Blvd. Smithfield, RI 02917

Telephone: (401) 349-5360

Fax: (401) 349-5270

FINANCIAL AND PAYMENT POLICY

Please read the following regarding our financial and payment policy and sign below:

It is the policy of Peter C. Brasch, M.D. L.L.C. that **the patient has the ultimate responsibility** for payment on his or her account. Payment in full is due and required at the time of service.

Insurance – In an effort to accommodate the needs of our patients, we have contracted with Medicare and many other insurances. The specifics of your plan that govern how claims are paid are outlined in the policy booklet you received when you joined the insurance plan you selected. It is your responsibility to read and understand your insurance plan's provisions and requirements. If we are not contracted with your current insurance, it will be necessary for you to pay in full for your visit at the time of service. We will provide you with an itemized receipt that you can send to your insurance company for them to reimburse you.

If your insurance requires a referral or authorization from your primary care physician (PCP) it is your responsibility to make sure that the referral is in our office at the time of your visit. If no referral is obtained, you will be required to reschedule your appointment.

If your insurance plan requires a specialist co-pay, that co-pay is due at every visit and is not an option. If you cannot pay your co-pay, be prepared to reschedule your appointment. It is also a requirement that costs not covered by your insurance, co-insurance, and deductibles be paid at the time of service.

Self-Pay Patients are required to pay for services at each visit at the time of service.

Appointment Cancellations and No Shows When you make an appointment, we reserve time specifically for you. Unfortunately, when a patient does not show for their scheduled appointment, another patient loses an opportunity to be seen. Therefore, if you need to cancel or reschedule, you are asked to notify us 24-hours in advance. **Appointments cancelled without a 24-hour notice will be assessed a cancellation / missed appointment fee of \$50.**

****** If your account becomes delinquent for noncompliance to our financial policy, and we feel it is necessary to involve a third party in the collection effort, we reserve the right to add a collection fee to your balance.

I have read, understand and agree to Peter C. Brasch, M.D. L.L.C's financial and payment policy.

I understand that charges not covered by my insurance company, as well as applicable co-payment, deductible, and out-of-network fees are my responsibility. In the event my account becomes delinquent, I understand and agree to pay the collection fees and / or attorney fees associated with the collection process. Failure to follow our policy may result in discharge from our practice. Peter C. Brasch, M.D. L.L.C. will not deny emergency care.

Patient Name (PRINT): _____

Signature: _____ Date: _____