

Financial Policies and Patient Responsibilities

- ◇ I certify that the insurance information is correct and true, and that I am eligible for health plan coverage and benefits for non-cosmetic procedures. I understand that if the information is NOT true or is I am NOT eligible under the terms of my Medical and Hospital Subscriber Insurance Agreement then I am liable for all charges for services rendered. Also, if the information is NOT true, I agree to pay in full for all services within **thirty (30) days** of receiving the bill from Suzanne M. Quardt, M.D., Inc.
- ◇ Your insurance company was your choice. Not all services may be covered under your particular insurance plan. All services NOT covered are your responsibility. Payments for services rendered, unpaid deductibles and copayments are due at the time of service.
- ◇ There will be a **\$25 charge** to patients that do not show for their appointment and for appointments cancelled less than 48 hours of the scheduled appointment.
- ◇ There is a **\$50 charge** for each check returned to us for insufficient funds.
- ◇ I directly assign all medical and surgical benefits to Suzanne M. Quardt, M.D., Inc. and understand that I am personally financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize Suzanne M. Quardt, M.D., Inc. to release all information necessary to secure payment of benefits. I agree that a photocopy of this agreement is valid as the original.
- ◇ Due to high volume of forms we are asked to fax and complete, there is a **\$5 charge per page** for each page copied and/or faxed per patient's request.
- ◇ There will be a charge of **\$50** for each Disability Form and other similar forms we are asked to complete.

Patient Name (Printed)

Witness Signature & Date

Patient Signature

Date