COMPREHENSIVE BREAST AND SURGICAL CENTER

M. Lisa Attebery, DO, FACOS | *Breast Surgical Oncologist & General Surgeon*

FINANCIAL POLICY

Thank you for choosing The Comprehensive Breast & Surgical Center as your healthcare provider. We have developed this policy to ensure patients understand their financial responsibilities for our services. Please read thoroughly, ask us any questions you may have, and sign below.

1. **PAYMENT -** Payment is expected at the time of your visit. We accept cash, check, or credit card. Payment includes any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit.
2. **INSURANCE –** We participate with several insurance plans and will file those insurance claims. Insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. ***Due to the many different insurance products available, our staff cannot guarantee your eligibility and coverage. You are responsible for obtaining a properly dated referral if required by your insurer.*** In the event your insurance plan determines a service is "not covered," you will be responsible for the complete charge.
3. **RETURNED CHECKS -** Returned checks will incur a $30 service charge. You will be asked to bring cash, a certified check, or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving additional services. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to The Comprehensive Breast & Surgical Center are subject to collections and may be prosecuted.
4. **ACCOUNTING -** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.
5. **COSMETIC CASES -** Cosmetic cases require 50% of the total cost at the time consent is obtained. The remaining balance must be paid in full 1 week prior to surgery or surgery will be cancelled.
6. **COLLECTION FEES -** I understand in the event my account is placed in collection status, any additional fees incurred will be added to my outstanding balance. This includes but is not limited to collection agency fees, court costs, interest, and fines. I understand these additional fees are my personal responsibility to pay in full.

Signature of Patient (or Guarantor, if applicable): _____ **Date:** _____

Printed Name of Patient: _____

Signature of Witness (required if patient unable to sign) _____

Jan 2022