# Nancy Curosh M.D., P.C.

## Appointment & Finance Policy

**Insurance:** Your insurance coverage is a contract between you and your insurance company. You are ultimately responsible for payment of your account and for securing referrals from your Primary Care Physician (if required by your insurance). We will assist by billing all insurance companies. Please provide us with complete and accurate insurance information, and keep our clinic informed concerning changes in address, telephone numbers, employer, etc.

**Medicare:** Nancy Curosh, M.D., P.C. is a participating provider and accepts assignment on all Medicare claims.

**Co-payments and deductibles:** Co-payments are due at the time of your appointment. Payments for services up to your annual deductible are also due at time of service.

**Services not covered by insurance:** If services rendered are not covered by your insurance carrier or if you do not have insurance coverage, you will be responsible for payment in full. You will be expected to pay at time of service.

**Returned Checks:** A fee of thirty-five ($35.00) dollars will be charged to your account for checks returned due to insufficient funds.

**Special billing arrangements:** If circumstances prevent you from paying account in full by the due date, please contact our billing service immediately to make special payments arrangements. If your account is sent to collection, you will be expected to pay cash at the time of visit for any subsequent office visits.

**Missed Appointments:** ***If you do not keep a scheduled appointment or cancellations without 24 hours notice, you will be charged $50 for your missed appointment.*** Insurance companies do NOT reimburse for missed appointments! Please be considerate of others as our appointment schedule fills quickly. Confirmation calls are courtesy and should not be counted on to remember your appointments.

**Arriving late for an appointment:** If you are more than ***10 minutes*** late arriving at the office for your scheduled appointment, YOU HAVE MISSED YOUR APPOINTMENT AND WILL NEED TO RESCHEDULE!

I have read and understand the appointment & finance policy.

I request that payment under my medical insurance program be made to Nancy Curosh, M.D., P.C. for any services furnished me, and I authorize Nancy Curosh, M.D., P.C. to release to my insurance, or for Medicare claims, to the Social Security Administration or its intermediaries of carriers, any information needed to process my claims. I further permit a copy of this authorization to be used in place of the original.

_____

Signature Date

DR. NANCY CUROSH, M.D., P.C.

I, (name of patient) _____ acknowledge and agree that I have been made aware of the Notice of Privacy Practices of Nancy Curosh, M.D., P.C. and should I request it, a copy of these practices will be made available to me.

_____

Patient signature Date

_____

Patient legal representative (if applicable) Date

_____

Print name of legal representative and relationship to patient

FOR CLINIC USE ONLY:

Nancy Curosh M.D., P.C. made the following good faith efforts to obtain the above referenced individual's written acknowledgement including the reasons (if known) why the written acknowledgement was not obtained.