

Glenn W. Knox, MD, FACS, PSC

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Financial Policy

PLEASE PRESENT YOUR INSURANCE CARD(S) AND A PICTURE ID

Payment for services is due at the time services are rendered. All co-payments or deductibles will be collected prior to your seeing the doctor. It is the patient's responsibility to show proof of the insurance deductible being met.

We require that patients update their personal information with each visit. If changes have been made with your insurance company or any other personal information, please let us know upon your arrival at our office. Failure to do so could result in a denial of payment by your insurance company. If your insurance plan requires a paper referral, please bring the referral with you. It is your responsibility to keep your referral current.

We will file directly with your insurance company based on the information that you provide. If this information is outdated or incorrect and the claim is denied, you will be responsible for payment. Please confirm our participation with your insurance company prior to your visit.

Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. Not all services are covered benefits in all contracts. Some companies arbitrarily select certain services that they will not cover, or will only partially cover. Please remember that our professional services are rendered to you, not the insurance company. Decisions made about your treatment are based on medical standards and the physician's judgment about what is best for your health. Therefore, payment for treatment is your responsibility. We allow 90 days for reimbursement from your insurance company. After 90 days, the balance will become your responsibility.

We do not accept Medicaid.

Your signature below indicates your acceptance of the above policy. It also indicates the following: I understand that I am directly and fully financially responsible to my physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I acknowledge that any co-pays, deductibles, or procedures not covered by my insurance company are my responsibility and must be paid at the time of service.

I further acknowledge and agree that if I fail to make timely payments on my account, I will be responsible for any and all costs of collection including filing fees, attorney's fees, and fees charged by a collection agency.

In the event of a returned check, there will be a \$40.00 fee which is payable in cash. The amount of the returned check will also be payable in cash. Any future payments will need to be made by cash or credit card.

There is \$60.00 charge for the cancellation of an appointment with less than a 24 hours' notice or for no-showing for an appointment.

Signature: _____ Date: _____