

Gregorio S Santos, M.D., P.A.
6125 54th Ave N, Suite B
Kenneth City, FL 33709
(727)521-9467 Fax: (727)521-0416

Financial Policy

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

2. INSURANCE We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service.

Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self pay patients.

3. RETURNED CHECKS will incur a \$30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the \$30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the \$30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Pinellas County.

5. ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. FORMS FEES: completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are \$25 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records is \$10 for the first twenty (20) pages and \$0.50 per page in excess of twenty. Gregorio S Santos, M.D., P.A. will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.

7. BILLING OFFICE: If you have questions in regard to any of your billing statements, our accounts receivable staff is available to assist you. CALL 727-521-9467.

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8. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a \$35 missed appointment fee.

9. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Gregorio S Santos, M.D., P.A. for charges not covered by the assignment of insurance benefits.

10. ASSIGNMENT OF INSURANCE BEBEFITS: I hereby assign, transfer, and set over directly to Gregorio S Santos, M.D., P.A. sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Gregorio S Santos, M.D., P.A. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Gregorio S Santos, M.D., P.A. I authorize Gregorio S Santos, M.D., P.A. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

12. SELF PAY PATIENTS: Evaluation and management charges will be discounted for prompt payment. Charges for supplies, tests, immunizations, medications, or procedures are never discounted. Gregorio S Santos, M.D., P.A. does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service.

13. RELEASE OF INFORMATION: I hereby authorize the and direct Gregorio S Santos, M.D., P.A. to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

14. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I certify that I have read these Financial Policies and Consent Procedures and understand and agree to be personally and fully responsible for payment.

Signature of Patient
(or Guarantor, if applicable)

Date

Please Print the Name of the Patient