Financial Policy and Assignment Agreement for BASS MEDICAL GROUP

Office copayments and coinsurance will be collected at the time of your appointment. Our practice accepts cash, personal checks, VISA and MasterCard**.** You will be charged $25.00 for returned checks or credit card. *Estimated Prepayment or credit card information will be required at the time of service if you have not met your deductible and out of pocket*.

Insurance
We bill participating insurance companies as a courtesy to you. If we do not receive payment from your insurance company you will be responsible to pay the balance in full.

Assignment Agreement
I request that payment of authorized benefits be made to Bass Medical Group for any medical services rendered. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay a claim.

Missed Appointments/Late Cancellations
Broken appointments represent a cost to us, to you and inconvenience to other patients who could have been seen in the time set aside for you. *We require a 24 hour notification for cancellation or reschedule of an office appointment or there will be a $50 charge*. Excessive abuse of scheduled appointments may result in discharge from the practice. *We require a 5 business day notification to cancel or reschedule procedures or there will be a $100 charge per procedure. For missed procedures without notification there will be a $200 charge*.

Consent for Treatment of Minor
This will authorize F. Anderson Rowe, M.D., and Julia DeRenzi, PA-C to perform any necessary or routine medical treatment including examination and diagnostic procedures.

Collections
Patients with an outstanding balance of 60 days overdue must make payment arrangements prior to scheduling appointments. For accounts 90 days overdue, patients will receive a final call from our billing office and payment arrangements must be made within 10 business days. *Accounts will be sent to Collections and a 25% collection fee will be assessed, if no patient response.*

____
Patient's Name (please print) Signature Date

If Minor or Responsible Party is other than patient, please fill out below:

____
Parent/Responsible Party's Name Signature Date

____
Address Home # Alternate#