Family Practice Associates
a professional corporation

Eugene D. Pogorelec, D.O.
M. Terrance Simon, D.O.
Wayne H. Lutzke, D.O.

Family Practice Associates, Inc
2300 Wales Ave NW
Massillon, OH 44646
(330) 832-3188
(330) 832-9936 (Fax)

FINANCIAL POLICY

Thank you for choosing our office as your health care provider. We are dedicated to providing the best possible care and services to you and you complete understanding of your financial responsibilities and privacy rights is an essential element of your care and treatment

Unless other arrangements have been made in advance by either you or your health coverage provider, payment is due at time of service. For you convenience we will accept Visa & MasterCard.

Your insurance policy is a contract between you and your insurance company. We have made prior arrangements with many health plans to accept assignment of benefits. We bill those plans for which we have arrangements and will require you to pay the authorized **co-payment at time of service.** All deductibles and out of pocket expenses will be collected at time of service.

As a courtesy to you, we submit you claim to the insurance company. If the insurance company does not pay within 60 days, you will be held responsible for payment. If your coverage is with a plan that we do not have prior assignment with, the charges for your care and treatment are due in full on the day of the service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service is to be "not covered" you will be responsible for the complete charge. payment is due at time of service.

An adult must accompany minor patients for each visit. In the event the accompanying adult is someone other than the parent, written permission from the parent must be obtained prior to treatment. In the event written permission cannot be obtained under certain conditions a phone call will be accepted.

If your visit pertains to an **Auto Accident** or **Workermen's Compensation** claim it is you responsibility to notify the receptionist so proper information can be collected to process your account.

In order to provide the best possible service and availability to our patients, we ask you call us 24 hours prior to your scheduled appointment time if you know you will need to reschedule. Please notify us of any extenuating circumstances.

There will be a $20.00 fee charged to you for NSF checks

Disputed Balances: Please check your statement carefully. We work hard to avoid errors, but if one should occur, please notify our billing department at 330-832-3188.

By utilizing the services of Family Practice Associates, Inc I agree to the terms of this policy. I also understand and agree that such terms may be amended from time to time. I have read and understand the financial policy of the practice and agree by it terms.

I understand a copy of the Privacy Notice is available to me upon request. I have either read this policy or have declined to read at this time.

_____

Signature of Patient or Responsible Party

_____

Date