



Sonya Lee, MD
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PAYMENT POLICY

Patients are responsible for charges including co-pays, deductibles, co-insurance or services that are not covered by their health insurance plans. Services may not be covered if there is a pre-existing condition clause, or if your plan does not cover preventative services. Student plans and basic plans often have limitations of coverage. All patients must provide a valid credit/debit card upon establishing care to be used ONLY if charges are not covered by your insurance plan and for our no show/late cancellation policy. **Your card will only be charged for balances after all payments have been received from your insurance company and it is determined that the patient is responsible for the balance.**

We will charge your card based on the statement called an explanation of benefits or EOB that we received from your insurance company. If your card is charged, we ask that you contact your insurance for an explanation as our charges are based solely on the information they provide us. You should receive an explanation of benefits notice from your insurance in the mail shortly after your visit.

CANCELLATION/NO SHOW POLICY

We ask that you please cancel your appointment with at least 24 hours' notice so that your appointment time can be offered to other patients. If less than 24 hours' notice, the appointment will be documented as "no show". You will receive an automated message notifying you of your missed appointment. After 3 "no-show/missed appointments, dismissal from our practice may be considered. **Your card will be charged as follows:**

**No Show/Canceled same day/Missed appointment/Laser \$25
Surgery Cancellation \$50 (less than 5 workday notice)
Sculpsure \$75**

Please be assured that all card numbers are kept in a secure password protected system. Before charging your card we will double check the claim to make sure it is correct and that our office has not made a mistake. By signing below, you acknowledge that you understand your financial responsibilities as a patient. You authorize payment in full via your credit card by your signature below for any and all payments due today and in the future dates of services, for consultation, evaluation and procedures performed. Please keep your credit card information updated.

By signing below, you acknowledge that you have had the opportunity to ask questions regarding this payment and cancellation policy and have had the opportunity to decline participation with the office.

COLLECTION POLICY

In the even that there is an outstanding balance on your account the following collection procedure will take place.

1. Your credit card on file will be charged for any balances as outlined in our payment policy above.
2. If a balance is higher than \$50 is owed you will be notified.
3. If we are unable to charge your account, after 90 days' notice and final notice, your account will be forwarded to Suburban Credit and Collections.

Credit Card #	Exp Date	3 Digit Code	Billing Zip
Print full name as appears on credit card	Signature	Date	