SUBURBAN ENDOCRINOLOGY AND DIABETES

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Dear Patient:

Our office is most happy to complete and submit claims to primary insurance plans. Please keep in mind that most insurance companies do not cover all procedures. We encourage you to discuss any questions you may have regarding your specific plan with our management. We encourage you to contact your insurance company to determine what coverage your plan provides.

Please read and sign below showing you understand the following:

- I understand that my insurance may/may not cover all medical services and that it is my responsibility to call the insurance company to verify coverage and to confirm that the doctor I am seeing is in the network.
- I understand that it is my responsibility to provide referrals or pre-authorization for services as required by my insurance plan.
- My insurance plan may have a deductible and/or co-payment amount. All co-pays are due at the time of service. Payment is **your** obligation regardless of insurance or other third party involvement.
- I accept full responsibility for all fees required for my child's medical care regardless of my marital status.
- I understand that missed appointments and cancellations without adequate notice (more than 24 hours notice) will incur a $35 charge for existing patients and a $60 charge for new patients prior to or at your next visit.
- In the event that I/my family want to transfer to another office, I understand that my balance must be paid in full to receive copies of medical records. There is a charge for duplication of medical records.
- I understand that if my check payment is returned as NSF from the bank there is a $35 NSF charge, which will be added to my account.
- I understand there is a $5 surcharge if I do not pay my co-pay on the date of service.
- I understand that I am responsible for any reasonable fees, expenses, or costs related to the collection of any unpaid balance, including commissions paid to attorneys or collection agencies.

Patient/Parent Signature _____ Date _____