

Renata Teytelbaum MD, AMMGC

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FINANCIAL POLICY

As a courtesy to you, our patient, we will file your insurance for you. However, since the coverage is a contract between you and the insurance company, it is ultimately the patient's responsibility to ensure that services are paid in a timely manner. If your visit or procedure is a non-covered benefit, according to your insurance policy, it becomes an expense billable to you.

If you are a member of an HMO, **it is the patient's responsibility** to be sure that we have obtained a referral for you for a specialist or procedure scheduled, **prior to your appointment**. Please be sure to give us at least 1 weeks notice to obtain a referral for you.

All co-payments are due at the time you sign in at the front desk, and are payable by cash or check only. If a check is returned by your bank for any reason, you will be charged a \$29.00 Returned Check Fee, which will be added to your account, and must be paid in full by cash prior to any follow up visits.

If you are a **self-pay patient** with no insurance coverage, all fees are due and payable at the time services are rendered.

If you are a **parent/guardian of a minor**, it is the responsibility of the parent who is seeking treatment for the child to ensure that payment is rendered accordingly.

By signing below, I understand that **I am responsible for payments of services provided**. If for any reason I am delinquent in my payments, I will be responsible for the Collection Fee of 30% and the outstanding balance on my account, plus any attorney's fees.

I acknowledge receipt of this financial policy and a copy shall remain in my chart.

CANCELLATION POLICY

Due to high demand for new patient appointments, we request cancellation notification 24 hours in advance. Failure to notify staff of a cancelled appointment will result in a \$50 cancellation fee for regular follow-up appointments, and a \$100 cancellation fee for physicals.

RELEASE OF INFORMATION

By signing below, I authorize Dr. Renata Teytelbaum MD to release any information with regard to my treatment, for insurance purposes. I also authorize the above physician to release my information to other physicians or institutions as necessary for my treatment.

I understand that any information given with regard to my treatment shall remain **confidential** and will be released only as necessary to my care or treatment.

SIGNATURE: _____ DATE: _____

PATIENT NAME: _____