FINANCIAL AND PRACTICE POLICIES

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy.

I understand that:

It is my responsibility to contact and secure from my insurance plan any referrals, pre-certifications or authorizations prior to receiving medical services from Ryan Crenshaw, M.D., P.C. If a referral is required and I do not bring it with me my appointment may need to be rescheduled.

All co-pays, coinsurance and deductible charges as well as past due balances, will need to be paid prior to services rendered. If I have financial difficulty and cannot pay a past due balance, I agree to make payment arrangements by credit card, which will be kept on file and charged at intervals agreed upon by the billing department and myself.

Dr. Crenshaw, M.D., P.C. will file for insurance benefits and accept payments per contractual agreements with participating insurance companies. Knowing the terms, limitations and guidelines of my health insurance policy it is my responsibility as a patient and I assume all financial responsibility for any charges incurred as a result of policy termination or coordination of benefits or limitations otherwise not mentioned that results in nonpayment.

Should any balances arise due to insurance copayments, coinsurance, deductibles, insurance denials, termination of coverage, or any other reason; I agree to pay all changes within 60 days of service rendered. Interest of one and a half percent (1.5%) per month, 18% per annum may be charged on all delinquent accounts over 60 days.

There will be a charge for medical records or any forms which need to be filled out by the physician.

There will be a $75 fee for missed appointments not canceled 24 hours prior to the scheduled appointment. A $250 fee for any procedure(s) not canceled 5 business days prior to the scheduled procedure(s). If you are a self-pay patient who has paid the $75 office visit fee in advance, this fee will be retained if the patient does not cancel with more than 24 hours notice.

If for any reason the check is returned on my account, I will be responsible for a $25 returned check fee in addition to the original fees for services.

If an outstanding balance is not paid within 60 days of the billing date, or if agreed upon payment arrangements are not made, Ryan Crenshaw, M.D., P.C. will retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and notify the credit bureau of any delinquencies. I understand that I will be responsible for all additional fees incurred from the attorney/collection agency.

Thank you for your cooperation.

I have read and understand the above financial policy.

_____	_____	_____
Signature of patient/guardian/parent	Print name of patient	Date