

Fred Wilder, M.D.

Financial Policy

As a courtesy to our patients, we are happy to file insurance on their behalf. However, the **ULTIMATE RESPONSIBILITY FOR ANY BILL IS WITH THE PATIENT**, and the patient will be held liable for the entire amount of the bill. *Please read the following section regarding your personal situation carefully so that any misunderstanding might be avoided.*

CONSULTATION/OFFICE VISITS:

The office visit / co-pay must be paid at the time of service. For cosmetic procedures the consultation fee is \$50.00. We do not file insurance unless we are a participating provider. Itemized bills will be given to the patient in order for you to file directly with the insurance company.

ELECTIVE/COSMETIC SURGERY:

Full payment is required two weeks prior to surgery. If payment is not received, your surgery will be cancelled.

INSURANCE FILING:

If your services or surgery are covered by insurance, we will file your claim as long as the bill exceeds \$500.00. We will need to collect a payment from you for your deductible and co-insurance. If your bill is less than \$500.00, payment will be required in full. If we do file insurance for you and the insurance company has not made payment within 30 days of filing, you will be required to pay the balance and we will refund anything we subsequently receive from your carrier. Please remember that you are responsible for your bill and that your insurance policy is a contract between you and your insurance company. **Any difficulty involving the amount paid or allowed by your insurance carrier is between you and the carrier. Please also note that you are responsible for any hospital, laboratory and anesthesia fees.**

I have read the above policies and agree with them.

Patient/ Parent/ Guardian Signature

Name (Please Print)

Date

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RELEASE OF MEDICAL INFORMATION: I hereby authorize the release of any information and/or medical records acquired in the course of my examination and treatment to consulting physicians, insurance companies, hospitals or affiliated clinics as deemed necessary by my physician to aid in my examination or treatment. I have read this policy and agree with it.

Patient/ Parent/ Guardian Signature

Date

Name (Please Print)