EDMUND KRASINSKI, JR., D.O., F.A.C.G., P.L.L.C.

PAYMENT AGREEMENT

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

IT IS THE PATIENT'S RESPONSIBILITY TO PAY THEIR CO-PAY AT TIME OF SERVICE BY CASH, CHECK, DEBIT OR CREDIT.

IT IS ALSO THE PATIENT'S RESPONSIBILITY TO HAVE THEIR REFERRAL AT THE TIME OF THEIR APPOINTMENT.

ALL CORRECT BILLING INFORMATION IS NESESSARY FOR US TO BILL YOU INSURANCE COMPANY.

WE CANNOT MAKE ANY EXCEPTIONS.

IF THE ABOVE QUALIFICATIONS ARE NOT MET, WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT.

REGARDING YOUR INSURANCE:

The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance plans.

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to above paragraph.

Any fees incurred by collection companies or attorneys for us to receive payment from patient will be an additional cost to the patient or responsible party.

FORMS: If your insurance company or employer requires us to complete disability forms, including FMLA forms, there will be a charge of $12.50 per each request (this includes copy of medical records if required).

PATIENT CANCELLATION AGREEMENT:

In the event that you are unable to keep your scheduled appointment we ask that you notify our office at least 24 hours in advance. If you are unable to keep an appointment for a scheduled hospital procedure we ask that you notify our office at least 48 hours in advance. We do not charge for missed appointments at this time: however, if you miss more than three office visits or hospital procedures, we will not be able to keep you as a patient. Please help us serve you better by keeping scheduled appointments.

Thank you for your understanding.

I have read, understand and agree to this financial policy.

_____ _____

Signed by patient or responsible party Date