PATIENT PAYMENT AND FEE AGREEMENT

It is our intention to provide timely care for all of our patients. When an appointment is not kept it means that other patients cannot be seen, and in some cases must go to the Emergency Department.

Therefore, we enacted a policy requiring a $25 to $50 fee for any patient that does not give us twenty-four (24) hours notice of cancellation or rescheduling of their appointment. This payment must be paid in cash before you can be seen again in our practice.

We will be happy to address any concerns you may have regarding this policy. Please see full list provided below, describing the financial circumstances of missed appointments.

Missed Appointment fees:
1st time no show or less than 24 hour cancellation: $25
2nd time no show or less than 24 hour cancellation: $35
3rd time no show or less than 24 hour cancellation: $50
4th consecutive no show or less than 24 hour cancellation will result in dismissal from the practice.

Other Financial Charges:
A $10 fee will be assessed if co-payment is not received at time of service.
A $20 fee will be assessed for any bounced checks.
A 30% collection fee will be assessed for any account that is sent to the collection agency.

I have read this form completely, and I certify that I am the patient or a duly authorized legal guardian of the patient, authorized to furnish the information requested. I understand that even though I may have medical/health insurance coverage, I am ultimately responsible for payment for all services rendered, including copays, deductibles, coinsurance and for any services which are not covered by my medical/health insurance. I also authorize the release of any medical or other protected health information ("PHI") needed in order to process claims and payments to Val Koganski, MD, PC, dba Newtown Internal Medicine. I realize if the claim goes to collection, I will be responsible for accrued interest and collection fees.

I, ____________________________ certify that I have read, understand and agree to the above policy.
(Print Your Name)

____ Signature of Patient / Patient Representative / Legal Guardian

____/____/____ Today's Date

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