SALEM PULMONARY ASSOCIATES, P.C.

Salem Pulmonary Associates goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy, allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions please do not hesitate to ask a member of our staff.

1. Upon arrival, please sign in at the front desk and present your current insurance card(s) at every visit. Please inform us of any changes in your personal information.
2. **It is your responsibility to understand your benefit plan. It is your responsibility if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure and what services are covered.**
3. **According to your insurance plan, you are responsible for any and all co-payments, deductibles and co-insurances.**
4. **If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit unless other arrangements are made. For scheduled appointments, prior balances must be paid prior to the visit.**
5. If you have no insurance, payment for an office visit is to be paid at the time of the visit unless other arrangements are made in advance.
6. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due 10 business days from receipt of your bill.
7. If previous arrangements have not been made with our finance office, any account balance over **90** days will be turned over to a collection agency.
8. **A $25 fee will be assessed for all appointments cancelled without 24 hour notice.**
9. **A $35 fee will be assessed for not showing up for your scheduled appointments.**
10. **Patients, who accumulate a total of 3 NO SHOWS/ SAME DAY CANCELLATIONS IN A CALENDER YEAR, will automatically be TERMINATED from SPA as a patient. EXCEPTIONS WILL BE MADE DEPENDENT ON CIRCUMSTANCES.**
11. **If you have not been seen in one (1) year Salem Pulmonary Associates WILL NOT REFILL ANY PRESCRIPTIONS UNTIL YOU ARE SEEN.**
12. A **$25** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name (Print):_____ Date:_____

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Patient, Parent or Guardian Signature