OFFICE FINANCIAL POLICY

You are responsible for all expenses incurred as part of your treatment. While my staff will assist you in filing for your insurance claims, payment is expected at time of service. If you belong to a managed care network, your insurance claims will be filed for you. Co-payments, non-covered services, and deductibles remain your responsibility and must be paid when services are rendered.

To aid in the billing process, please provide my staff with accurate information about your insurance carrier as well as your ID number. Please have your insurance card available at the time of visit. You are responsible for the balance remaining after payment from the insurance company is received, or if payment is not received from the insurance company in a reasonable amount of time.

A 24-hour notice is required for cancellation of appointment. A fee of $25.00 will be charged for those who cancel with less than 24 hours notice or do not show up for their scheduled appointment.

I acknowledge that I have read and understood the office financial policy for Gerardo P. Sison, Jr., M.D.

_____
Patient/Parent Signature or Guardian

_____
Date

FEE SCHEDULE:

This is not a comprehensive list of all fees in this office. Please inquire about current fees prior to authorizing any service that is not covered by our insurance company. Please initial EACH item.

* $25 Return Check fee for checks of $49.00 or less

* $35 Return Check fee for checks greater than $50 but less than $300.00

* $25 No show or late cancellation fee

*$50 Disability and/or FMLA form preparation (1-2 pages)

*$95 Disability and/or FMLA Form preparation (3-4 pages)

I have read, understood, and agreed to the above fees.

_____
Patient/Parent Signature or Guardian

_____
Date