2800 Tamarack Ave, Suite 104, South Windsor, Ct. 06074

# PAYMENT POLICY

If you do not have insurance, payment will be expected on the day service is provided.

All **co-payments** must be paid when checking in with the receptionist.

As a courtesy to our patients, we will file an insurance claim for service provided only if you have **provided us with complete and correct subscriber insurance information** and that you have signed the authorization section on our Patient Information Sheet.

If you belong to a managed care insurance plan, you signed a contract that does not allow you to see a specialist without prior approval from you primary care physician (PCP).
If we do not have a documented referral from your primary care physician's office prior to your appointment, your **visit will not be covered by your insurance and you will be responsible for the payment on that date of service**. These are the guidelines set up by your insurance company and stated in **your** Insurance Policy Manual. Within 30 days, you will receive a statement of your account. It will show the total amount due by your insurance and the amount due by you. We will expect full payment on your account within 45 days of the date of service. If payment has not been received by that time, you will receive a **PAST DUE** letter as a warning. A phone call will follow. We suggest that you call your insurance company and find out why no payment has been made and that you make full payment on the amount which is your responsibility. If payment is not made within 60 days, we will take further **collection action**.

If in the event there is a duplicate payment on your account and it shows a credit balance, we will refund the amount immediately either to you or the insurance company depending on responsibility.

All checks returned for **NON-SUFFICIENT FUNDS** will be subjected to a $25.00 additional charge.

**If you are unable to keep your scheduled appointment, you must notify our office 24 hours prior to your visit. If you do not call the office you will be charged a $25.00 fee for no show.**

If you have any questions, please feel free to give the office a call.
**I have read and understand the above payment policy.

**Date__________________ Responsible Party __________________________________**