FINANCIAL POLICY

We are committed to meeting your health care needs. Our goal is to keep your healthcare insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. Payment is expected at time of service. This includes all co-pays, co-insurance and/or applicable deductibles. There will be a $10 billing charge for "set" co-payments not made at time of service. We accept cash, checks, money orders and Visa/Mastercard.
2. **There will be a charge of $25 for all checks returned to us for insufficient funds and a $5 charge for a declined credit card.**
3. As a courtesy, we will file insurance paperwork for you. You will be responsible for any and all services in excess of your insurance limits as well as all non-covered procedures. If your insurance carrier will not allow you to assign your benefits to us, you must pay in full at the time of service and we will provide you the necessary information to seek reimbursement from your carrier.
4. If you do not have insurance, full payment is due at time of service.
5. If you are unable to make your appointment, you must provide us 24 hours advanced notice. If you fail to do so, you will be charged $25.00 for the first insufficient notice, and $50.00 each time thereafter.

We will mail to you a monthly billing statement for any outstanding balances. **For any balances, we expect payment in full, upon receipt of statement. If full payment if not made, applicable service & interest charges will apply.**

I hereby authorize George Rappard M.D. Inc., and their billing management company Siena Healthcare Solutions, LLC, to bill my insurance company/companies directly for all medical services rendered by staff and for said insurance company/companies to remit all payments directly to George Rappard, M.D., Inc., at PO Box 9155, Glendale CA 91226-9155.

Should my account, or an account for which I am financially responsible, be referred to a collection agency for non-payment, I am aware that I will be responsible for all charges incurred by George Rappard MD Inc. from the collection agency, not to exceed 40% of the balance owed. I also agree to be financially responsible for reasonable attorney fees. Non-payment may result in being reported to a credit bureau.

I acknowledge that I understand and accept this financial policy.

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Signature Date