

**Jacksonville Surgical Associates, P.A.**  
**Financial Policy**

Thank you for choosing our practice! We are committed to the success of you/your child's medical treatment and care. Please understand that payment of your bill is part of this treatment and care. **Please read over the form.** Patient/Parent/Legal Guardian signature is required at the bottom.

**ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable deductibles, co-insurance (i.e. "80%/20% coverage") and co-payments for participating insurance companies. Jacksonville Surgical Associates, P.A. accepts cash, personal checks, VISA, MASTERCARD OR AMEX. There is a service charge of \$30.00 for returned checks.

We realize that people have financial difficulty. However, patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

**MANAGED CARE**

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we will assist you in contacting your primary care physician prior to your appointment. If you are unable to obtain the referral at that time, you will be rescheduled.

**FORM PREPARATION**

Forms preparation is time consuming and we receive numerous requests for disability forms and FMLA paperwork etc. Accordingly, there will be a flat fee of \$25.00 payable in advance for any forms that a patient requests the doctor prepare or fill out.

**MISSED APPOINTMENTS/LATE CANCELLATIONS**

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you or your child. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge \$30.00 for missed or late/cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

***I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my or my child's insurance company, as well as applicable co-payments and deductibles are my responsibility.***

***I authorize my insurance benefits be paid directly to Jacksonville Surgical Associates, P.A.***

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date