OFFICE FINANCIAL POLICY-2020
C. CHRISTOPHER STROUD M.D., P.C.

The following represents our office financial policy. **PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.** This includes all co-pays, deductibles and coinsurances.

INSURANCE COVERAGE:

1. Is a contract that exists between you and your employer (or spouse's employer) and the insurance company. Our relationship is with YOU, the patient, and not the insurance company.
2. We **STRONGLY** encourage you to be educated on what your insurance covers, need for referral and which "network" you are required to use, if any.
3. All charges are the responsibility of the patient. We will bill your insurance company, but any services not covered will be your responsibility.
4. We rely on YOU to inform us of ALL insurances available and expect patients to notify the office immediately of any changes to their insurance status. If this information is not provided, or withheld at the time service is rendered, you will be responsible for these charges. It will then be your responsibility to collect from the insurance company.
5. Regarding worker's compensation and/or automobile claims:
   - If your claim is being disputed, you are responsible for payment. This dispute is your responsibility, even if there is an attorney involved or a claim is in progress.
   - Your health insurance carrier will not be billed until the dispute is settled.
   - We will gladly provide you with necessary paperwork/ documentation at your request. A fee may be required for this service.

OUTSTANDING BALANCES:

1. Patient account balances must be paid at time of treatment or within 30 days. A rebilling charge of $5.00 may be added each month to unpaid balances over 30 days. Unacknowledged invoices over 90 days old will be forwarded for further collection efforts. Charges associated with these actions will be the responsibility of the patient.
2. If paying the balance in full is not possible please speak with **our billing service at (248) 234-4210.** To determine if payment arrangements can be made.
3. If payment is not made when due, or you otherwise fail to comply with your patient obligations, we reserve the right to terminate our relationship with you, in accordance with applicable ethical standards. If your account becomes delinquent all balances must be paid in full prior to being seen and a **$50.00 deposit** will be required prior to any future appointments. This will be refunded if insurance covers any fees.

OTHER FEES:

1. $ 40.00 charge for returned checks
2. $ 10.00 fee per form for completion. We require ONE-week from time of receiving any form for completion.
3. $ 10.00 xray copies. We require ONE week notice to make a copy.
4. $ 1.00 per page fee for record request/ record copying
5. All Fees are due at the time of information request.

I have read ,understand and accept the office financial policy of C. Christopher Stroud M.D., P.C

Patients Name (print):_____

Patient's/ Guardian Signature:_____ Date:_____