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**OFFICE FINANCIAL POLICY**

Thank you for choosing us as your Health Care Provider. We are committed to helping you receive the best possible treatment available. Please understand that payment of your bill is considered a part of your treatment. Due to the vast amount of insurance plans, it is impossible for us to be aware of each patient's coverage. Please be aware of any benefits limitations your plan may have. If we do verify your benefits, and obtain authorization, please understand that this is still NO guarantee of payment or that the information that we are given is correct. We are NOT responsible for insurance company errors. It is your responsibility to pay any co-pays, deductible amounts, co-insurance or any balance left unpaid by your insurance company at the time of treatment. **Please be advised: It is important to record the correct insurance information at your initial visit.**

**TODAYS METHOD OF PAYMENT (Please check one)**

**ALL PATIENTS MUST COMPLETE AND SIGN THIS FORM PRIOR TO SEEING THE DOCTER.**

1. Cash\_\_\_\_
2. Credit Card-- Mastercard\_\_\_\_ Visa\_\_\_\_
3. Check\_\_\_\_
4. Insurance to be filed\_\_\_\_(only if Dr is participating in the plan)

*There is a \$25.00 fee for NO SHOW office visit appointments and \$100.00 fee for NO SHOW office surgery appointments and insurance is not billed. There is a \$25.00 charge for all returned checks.*

**I have read this financial policy. I understand and agree to this policy.**

X\_\_\_\_\_ Date\_\_\_\_\_  
Signature of patient/responsible party

\_\_\_\_\_  
Signature of Office Personnel