OUR FINANCIAL POLICY

Thank you for choosing Dr. Festa as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we would like you to read and sign.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, VISA,MASTERCARD,DEBIT CARD, AMERICAN EXPRESS, AND ATM CARD.

Regarding insurance:
If we are a participating provider of your insurance plan, we would appreciate all copayments and deductibles to be paid at the time of your office visit.

Referrals must be present at time of service. If you fail to provide us with this referral, charges will be your responsibility. ALSO IT IS THE PATIENT RESPONSIBILITY TO MAKE SURE THE REFERRAL ON FILE IS CURRENT.

If we do not participate with your insurance plan, we would appreciate payment in full at the time of service. We will give a receipt to submit to your insurance carrier for the reimbursement.

Non-Covered Services:
Please be aware that some of the services provided today may be non-covered services and not considered reasonable/necessary under your insurance plan. In such a case, these services then will become your responsibility.

Missed/Cancelled Appointments:
In the event you cannot make your appointment with us, we would appreciate you calling us at least 24 hours in advance. If you do not call within a 24 hour period, there will be a $50.00 charge.

I HEARBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES RENDERED. I FUTHER AUTHORIZE THE PHYSICIAN AND/OR SUPPLIER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THE INSURANCE CLAIM. I UNDERSTAND ANY BALANCE OVER 90 DAYS I WILL BE RESPONSIBLE FOR. THIS FORM WAS COMPLETED CORRECTLY AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE AF ANY INSURANCE CHANGES.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

SIGN: _____ DATE: _____