

# DeAnna Bullaro-Anderer DO, FACOOG

## Financial Policy Guidelines

### Welcome

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. In order to reduce potential confusion, we have adopted the following Financial Policy Guidelines. Please read and sign it prior to the commencement of any treatment.

### Appointments

To schedule an appointment, please call our office at (480) 237-3040. We strive to provide the best possible service and availability to all of our patients. If you cannot keep a scheduled appointment, please call **at least 24 hours in advance** to cancel so that we can schedule another patient. Many patients have urgent needs, so we use appointment cancellations to accommodate their special needs. Patients with missed appointments or short-notice cancellations (under 24 hours) will be charged a fee of \$25.00. This fee is not billed to your insurance company and is solely your responsibility. If you call for an urgent appointment but your regular provider is unavailable, we will schedule you with another provider. Your appointment will be scheduled to address your urgent problem.

### Insurance

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service is “not covered”, you will be responsible for the complete charge. This office is not responsible for disputing your insurance company’s decision regarding coverage. **We expect that you know your insurance benefits including, but not limited to: deductible and co-payment amounts as well as labs, radiology facilities and hospitals contracted with your plan.**

If you have insurance coverage with a plan in which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. You may, however, bill your insurance company, even if we are not a contracted provider. Our office will furnish you with the necessary paperwork to do so.

### Administrative

Your insurance is your responsibility! As a courtesy to our patients, we will file claims for these plans which we have an agreement. It is your responsibility to notify our office with current and valid insurance information. If your insurance company does not pay within a reasonable amount of time, we will look to you for payment. Any costs incurred by this office because of incorrect information provided to us will be your responsibility. Payment is due upon receipt of a statement from our office.

**All monies owed, including copays, deductibles or outstanding balances are collected at the time of service**

**Administrative Fee – \$25.00 fee for NSF check fee, FMLA paperwork, account ledger charges**

**(letters to insurance companies or other providers)**

**\$15.00 fee for patient records**

**\$10.00 fee for written prescription replacement**

**\$25.00 fee for no show appointments**

**If this account should go into default you understand that you may be held liable for all reasonable collection fees and attorney fees incurred to collect this debt.**

**If your account has a credit of \$25.00 or less, this money will be held on the account for future visits. If you do not wish this money to be used for future visits please contact Ryan Spielman at 888-962-9991, to request a refund.**

**Authorization**

I hereby authorize Dr. DeAnna Bullaro-Anderer to release any information to my insurance company for payment of my medical charges, or to review activities related to my health care provider's participation with my health plan. I assign to Dr. DeAnna Bullaro-Anderer any and all benefits to which the patient or insured party is entitled for medical services rendered. As a team, we hope to provide the best care to make your visit as pleasant as possible. Your signature below acknowledges that you have read and understand our policies.

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Please Print)

**Minors**

A parent or legal guardian must accompany a minor patient on his or her first visit to our office so we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian if we have written permission from the parent or legal guardian. The adult accompanying the minor patient is responsible for payment of the services at the time of services.

**Authorization To Treat A Minor**

I, \_\_\_\_\_, being the parent or legal guardian of the minor child, \_\_\_\_\_, do hereby authorize any provider, to treat the aforementioned minor.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_