



## Fall General Surgery, LLC

216 3<sup>rd</sup> St. W, Ste. 201, Ashland, WI 54806  
1420 London Rd, Duluth, MN 55805

### Financial Policy

Welcome to Fall General Surgery. We have made it our mission to consistently provide outstanding patient care. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our billing coordinator at (715) 685-0656.

Your clear understanding of our Financial Policy is important to our professional relationship.

WE ARE HAPPY TO BILL YOUR INSURANCE DIRECTLY; HOWEVER, WE MUST HAVE A CURRENT COPY OF YOUR INSURANCE CARD.

WE ASK FOR A COPY OF YOUR ID OR DRIVER'S LICENSE DUE TO THE MANY CASES OF IDENTITY THEFT.

WE ACCEPT CASH, CHECK, VISA/MASTERCARD, DISCOVER, CARE CREDIT, AMERICAN EXPRESS AND HEALTH SAVINGS ACCTS.

ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" AND OTHER RELATED FORMS.

PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE COVERAGE.

5 BUSINESS DAYS NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS. THERE MAY BE A NOMINAL FEE FOR THIS SERVICE.

**INSURANCE COVERAGE:** All co-payments and estimated of out-of-pocket expenses are your responsibility. If you are unable to pay this estimate, we may ask you to reschedule your appointment. We are members of most, but not all plans. You are responsible for verifying that Fall General Surgery is an in-network provider for your plan. We encourage you to refer to your benefits manual if you have any questions about covered services. **Be aware that some and perhaps all of the services provided may be not covered by your insurance. You will be responsible for payment of all non-covered services.**

**PATIENT PAYMENTS:** It is the responsibility of the patient to pay his/her co-payment, deductible and any unpaid portion of the bill. You may use cash, check, credit/debit card, Care Credit or a health savings account to pay your balance. For those with a high deductible policy, our Patient Accounts Manager can discuss with you a good-faith estimate of your out-of-pocket expenses. Patients without insurance must pay in full prior to services being rendered. Patients should consult with our Patient Accounts Manager for payment options.

**LATE OR NO PAYMENT ON ACCOUNT:** Any patient that does not pay their agreed payment, or is late with their payment, will be assessed an 18% annual fee that will be added to the billing cycle from first date of service.

**"NO SHOW" APPOINTMENTS:** Any patient who calls our office after their missed appointment, or simply does not show up, will be considered a "no show". Three or more "no shows" will result in dismissal from the clinic.

**RETURNED CHECKS:** There is a \$35.00 fee for all returned checks.

I have read, understand, and agree to abide by the terms as written above.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_