NOTICE OF OFFICE POLICIES

Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when you pay for our services at the end of your visit. Our office staff can tell you the estimated fee for treatment before your appointment. To make payments easier and convenient for you, we accept cash, personal and business checks, Visa, Discover, and MasterCard.

We will cooperate fully with all our patients who are covered by insurance plans. Dr. Zeger assumes no responsibility should patient (Parent or Guardian, if Minor) err in the utilization of their insurance according to their insurance companies rules, regulations limitations and requirements. It is important that you understand that in most cases your insurance is designed to reduce your cost, not eliminate it completely. You are ultimately responsible for the full amount of your bill regardless of your insurance coverage. Please note that there are a few insurance companies that will not reimburse the Doctor directly, necessitating payment in full at the time of service.

Patients having insurance are expected to pay an estimated co-pay based on a percentage of the total charge at the time of service. Any insurance payment not received after 60 days of filing then becomes the responsibility of the patient. Payment from the patient is expected within 10 days of notification.

If your account is outstanding for more than 60 days, it will be turned over to our collection service and a 25% collection fee will be added.

Any checks returned to our office for non-payment are subject to an additional fee of $25.00. Immediate remittance in the form of cash, money order or certified funds is expected.

I consent to the use and disclosure of the patient's protected information for treatment, payment and health care operations. I do assign insurance benefits to be paid to Dr. Kirk M. Zeger that would otherwise be payable to me.

If, at anytime, you have a question about this policy or your account, please do not hesitate to contact our business manager. I have read the above policy and agree to accept financial responsibility.

Signature of Patient/Guardian:_____Date:_____

I do not wish to assign insurance benefits. This would require payment in full at the time of service. Initial:_____.