Elisabeth Potter, MD, PLLC

Financial Policy

Medical Insurance

Providing quality medical care to our patients is our primary concern. With your cooperation and assistance, you should be able to receive all of the benefits offered to you by your health plan allowing our physicians the opportunity to concentrate on caring for your medical needs. In order to facilitate your care, we ask that you read and follow these guidelines.

- Please bring your insurance card to all office appointments.
- If you have an HMO or other managed-care policy, please consult the referral rules in your health plan. Due to HMO regulations and restrictions, we may have to cancel or reschedule your appointment until a referral is obtained. Depending on your particular plan, the referral may be good for one year or only two visits. So that you are better informed, please verify the number of visits permitted. You will be responsible for any visit not authorized.
- We will collect all applicable co-pays, co-insurances, and deductibles at the time of service.
- Our office will be glad to process your insurance claim for procedures. Prior to your procedure, we will pre-approve the procedure with your health plan and determine any payments for which you may be responsible. We will collect the patient responsibility portion for your procedure prior to scheduling the procedure. Please be sure that we have your correct insurance information. If your carrier requires pre-approval or special forms, please notify and discuss with our staff before your procedure.

Self Pay

Payment is expected at the time service is rendered. However, treatment decisions are based solely on the patient's medical needs. We will not deny critical care to anyone due to their inability to pay or lack of insurance. Patients who have financial constraints should speak to our staff for assistance.

Financial Responsibility

I hereby authorize payment of medical benefits directly to Elisabeth Potter, MD, PLLC and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include the release of medical information. I also understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Elisabeth Potter, MD, PLLC. I further understand that should my account become delinquent, I must pay the reasonable attorney fees or collection expenses of Elisabeth Potter, MD, PLLC, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered. I acknowledge and agree that I have reviewed this Financial Policy in its entirety and been given the opportunity to ask questions. I acknowledge and agree that I have had all my questions answered to my satisfaction.

Patient Signature (or authorized person) _____

Relationship to Patient _____ Date _____