Blanzy Clinic, P.C. 14319 Dix-Toledo Road, Southgate, MI 48195

Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance. We accept Visa, MasterCard, Discover, American Express, Cash and Checks.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words; you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from you insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. All Diet program fees are due at the time of service. We do not bill insurance programs for these types of charges.

7. We charge for filing of disability forms, medical necessity letters, & handicap applications

8. We charge if your referral needs to faxed for your specialist appointment.

9. We charge for failed appointments or for those not cancelled within 24 hours if appointment is not filled.

10. If your account is turned over to a collection agency you will be responsible for the fees they charge us to collect on your balance.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party, if minor) Date

Please print the name of the patient (form effective 3/06)