Robert M. West, D.O.

PATIENTS HAVE THE RESPONSIBILITY TO:

- Provide information needed to the professional staff in order to care for you, and to follow instructions and guidelines given by those proving health care services.
- Keep all scheduled appointments and be on time, or to please give other patients who may use this appointment time the courtesy by contacting at least 24 hours in advance to cancel your appointment if you are unable to keep your appointment. You, the patient, will be charged a $25. fee for failure to cancel your appointment in a timely manner.
- Pay your share of fees or co-payments **at the time** of service.
- Provide insurance information that is accurate and current.

FINANCIAL POLICY

Patients who have medical insurance should know that ALL services are charged directly to the patient, and that he or she is responsible for payment. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are YOUR responsibility from the date of services rendered.

All insurance forms processed by this office, prior to payment in full are assigned to this practice. Your cooperation in complying with the terms of this assignment will be appreciated. Most misunderstandings about insurance can be avoided if you understand what your insurance policies are.

LABORATORY AND OTHER TESTS DONE OUTSIDE THIS OFFICE

You are responsible for ensuring that laboratory and other test(s) are done at a provider that is contracted with your insurance company. Consult the Member Services Department of your insurance company for assistance.

STATEMENT OF FINANCIAL RESPONSIBILITY

I have read the above and realize that all medical charges incurred by me or my dependants for services rendered by Robert M. West, D.O. and / or his associates, are my financial responsibility.

I hereby assign payment of authorized medical and/or surgical benefits to include major medical benefits to which I am entitled, to be made on my behalf to Robert M. West, D.O. and / or his associates for any services rendered by that physician. I authorize release of medical information to the insurance company that is needed to determine these benefits payable to the related services.

I understand that I am financially responsible for ALL charges whether or not paid by said insurance company. I also understand that all office co-payments are due at the time the service. In the event that I fail to pay these charges, I will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving my account. All balances over 30 days are subject to a 20% interest charge. There will be a $20.00 charge on all returned checks.

I have read this form, and as such, I realize by signing below, I understand and agree to comply with the above terms.

Patient Signature (or Legal Guardian) Date

2315 Dougherty Ferry Rd. Ste 107
314. 966.7570 ● Fax: 314.966.7788