Capitol Endocrinology Inc.
3106 Ponte Morino Drive, Suite C
Cameron Park, CA 95682
Tel (530)677.0700
Fax (530)676.7850
www.capitolendo.com

FINANCIAL POLICY

1. We accept most insurance plans. Please call us if you have any specific questions.

2. Payment is due at the time of services unless arrangements have been made in advance by your Carrier. We accept cash, checks, money orders and most major credit cards.

3. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As service to you, we will file your insurance claim if you assign benefits to your doctor in other-words, if you agree to have your insurance company pays 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 your insurer, we will refund any overpayment to you.

4. 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.

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 statement from our office.

6. Our billing company will send monthly statements to inform you of any balance due. We expect that patients due balances will be paid upon receipt of our statement. Any remaining unpaid balance will be collected at the time of your next visit. You also have the option to pay over the phone. Should there be an issue with your ability to pay, we encourage you to contact our billing service and arrange a payment plan for your balance due.

7. If necessary, unpaid past due accounts will be forwarded to an outside collection agency. All cost of this process will be your responsibility.

8. Our billing professionals will do all they can to communicate with you and your insurance company to resolve any issues. Questions regarding billing issues can be directed to our professional billing office at 1-866-949-4565 (Toll free)

9. I understand that it is the policy of this office to charge $25 fee for any returned / bounced checks or cancellation less than 48 hours of visit /no show.

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

Name of patient _____ Date _____

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