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Brian Stephens, M.D., F.A.C.O.G.
Lisa Graessle, Nurse Practitioner

FINANCIAL POLICY

Welcome! We appreciate the opportunity to participate in your care. Please read and sign the following Financial Policy, and complete our Patient Information sheet prior to being seen.

MEDICARE PATIENTS: WE DO ACCEPT MEDICARE ASSIGNMENT, Annual examinations and other items may not be covered by Medicare. You are responsible for payment at the time of service for non-covered services. **IF YOUR SECONDARY INSURANCE SENDS YOU THE PAYMENT, ENDORSE AND SEND TO OUR OFFICE IMMEDIATELY.** All Medicare fees are set by the government, not this office.

INSURED PATIENTS: All insurance policies are different, and it is your responsibility to understand your insurance policy. If you have a managed care plan, such as an HMO, PPO, MEDICAID, ETS., it is up to you to understand how your plan works and to bring the required insurance card and referral forms with you at the time of your visit. If your policy requires a referral form and you do not bring one, we can not see you that day, and will have to reschedule your appointment for another day. **WE ARE NOT RESPONSIBLE FOR GETTING THE REFERRAL FORMS FOR YOU.** Your Copayment is due at the time of visit.

SELF-PAY (NON-INSURED PATIENTS): Arrangements must be made prior to scheduling your visit as to how you plan to pay your bill. If you are suffering a financial hardship, and Extended Payment Plan is available for qualified applicants. We will accept cash, checks, Visa or Mastercard.

MAJOR SURGICAL PROCEDURES: Hospital, Radiology and Anesthetic charges are billed separately, and we are not responsible for this billing. We will precertify and all surgery procedures, and you will be contacted only if we have a problem with your insurance company. You are responsible for paying all fees, most of which are established by Federal laws.

MINORS: Adults accompanying children or requesting services are responsible for payment, regardless of who has custody of the minor.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

X _____ Date _____
Signature of Patient or Responsible Party

THE HEALTH PLAZA AT ST. MARYS

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