VALLEY COLORECTAL SURGEONS

PROCTOLOGY & COLORECTAL SURGERY
CHARLES N. HEADRICK, M.D., F.A.C.S.
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JEFFREY P. LAKE, M.D., F.A.C.S.

PLEASE REVIEW AND COMPLETE

If this form is not completed, the patient will not be allowed to see the Provider. Please initial each bullet point.

Patient Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Responsible Party: _____ Relationship to Patient: _____

Please read and initial the following:

- All co-payments, co-insurance, deductibles and cash-based amounts are due at the time of your appointment. _____
- Your insurance may **NOT** cover all of the services we provide. It is your responsibility to know what is and what is not covered. _____
- If your insurance company requires a referral or authorization for your visit, we will make every effort to obtain one for you but it is your responsibility to make sure your referral and authorization is in place. It is also your responsibility to make sure that we are a participating provider. _____
- Returned checks are subject to a $35.00 fee. _____
- You are responsible for your bill, and insurance companies are billed as a courtesy to you. If your insurance is delinquent, denies payment, or applies an amount to your deductible, you are responsible for the outstanding balance. Should your account become delinquent, you are responsible for any and all legal fees, court costs, and late fees. In addition, an administrative processing fee of $50.00 will be added to all delinquent accounts. _____

I have read, understand and agree to comply with the above financial and billing terms. I understand and agree that I am financially responsible for non-covered or denied services.

_____

Responsible Party Signature Date