

**ROCHESTER INTERNISTS, PLLC
FINANCIAL POLICY**

Please Only Fill Out If You Want Us To Save Your Payment Method

The physicians and staff of Rochester Internists provide professional health services. This statement will clarify the payment policies for our practice.

Your insurance policy is a contract between you and the insurance company. It is your responsibility to know what type of coverage you have. We will bill your insurance carriers, but cannot guarantee benefits or amounts covered. **You are responsible for the balance of payment.**

Insurance deductibles and copays are due at the time of service. Adults accompanying a minor are responsible for the payments of the service.

There will be an additional service charge of \$5.00 if co-pays are not paid at the time of the service.

Payment methods include check, cash, Visa, Mastercard or Discover. Questions regarding this policy statement or payments method may be directed to our billing manager.

Clients/Patient Name: _____

Credit Card Type: _____ Expiration Date: _____

Credit Card Number: _____

Yes- I authorize automatic credit card billing after each appointment.

Client/Patient signature: _____ Date: _____

PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGE IN THIS ARRANGEMENT.

PLEASE PROVIDE AN EMAIL ADDRESS AND WE WILL EMAIL YOU A RECEIPT.
