Sotolongo Clinic Financial Policy & Notice of Privacy Practices

* I understand payment is expected at the time of service. Checks and payment arrangement are no longer accepted.

* I understand that I am responsible for any co-payments, deductibles, non-covered services, and/or supplies at the time services are rendered.

* I understand that as a courtesy to me, my medical services will be filed with my insurance carrier.

* I understand it is my responsibility to know my insurance coverage.

* I understand that I am liable for any services denied and/or not covered by my insurance carrier.

* If payment is not made after reasonable notice of any balance due on my account, I will be responsible for all collection effort fees, including attorney and court costs.

* I have been offered and/or received a copy of the Notice of Privacy Practices.

You may share my medical information with the following people:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

X_____

Patient / Parent / Guardian / Advocate Signature Date Signed

Updated 10/17