I. **PAYMENT POLICY AND AGREEMENT** – In order to prevent any misunderstanding about medical insurance, we wish to point out that:

(1) All medical services furnished are charged directly to the patients.
(2) Payment is requested at the time of service unless you have HMO or PPO insurance
(3) Patients are personally responsible for payment of bill.
(4) If due to unforeseen circumstances, additional procedures and/or treatments that are done, patients must make arrangement for payment.
(5) Patients are expected to keep their accounts current while waiting for their insurance company to make payment.

Your insurance coverage is a contract between you and your insurance company to help you meet medical expenses. It is not possible for us to provide services on the basis that your insurance will pay all charges because coverage's vary so greatly. Please feel free to discuss charges with us at any time.

II. **METHODS OF PAYMENT** – We accept payments by Cash, Check, Visa and MasterCard. We charge a Returned Check Charge of $25.00 per check for any check returned unpaid by your bank for any reason.

III. **ASSIGNMENTS OF BENEFITS** – I hereby authorize JAN E. LEO, M.D. to release necessary medical information to my insurance carrier to process my medical claim. I also authorize my insurance carrier to pay any benefits directly to JAN E. LEO, M.D.

IV. **FINANCIAL DISCLOSURE TO PATIENTS:** This is to inform you that JAN E. LEO, MD uses licensed physician assistants and nurse practitioners to assist them in surgery, in the hospital and office. The physician assistant or nurse practitioner may also perform history and physical exams. Your insurance company may or may not cover all charges for your surgery, including those of the surgeon and the physician assistant. These surgery charges are considered usual and customary, but the insurance company may deny payment based on any number of reasons. You agree to be financial responsible for any charges denied by the insurance company. Your signature will acknowledge receipt of this information.

I, the undersigned, have read and understand the above policy and agreement and hereby consent to the above.

Signature of Patient or Responsible Party: _____

Date: _____