ASSOCIATED PHYSICIANS OF SOUTHBURY, PC
INTERNAL MEDICINE

MICHAEL TRAGER, M.D.
GINA RUPERT, PA
TRISHNA WALSH, PA

FINANCIAL POLICY

In order to avoid confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions please discuss them with our office manager. Your medical care is our foremost priority. We feel your complete understanding of your financial responsibilities is essential for maintaining an optimal relationship with our practice.

Unless other arrangements have been made in advance by either your insurance company or yourself, full payment is due at the time of the service. For your convenience we accept Mastercard, Visa, Discover and debit cards.

For insurances that we are contracted to accept assignment you are only required to pay your copayment, if applicable, at the time of your appointment. Any qualified amounts submitted to the insurance company for payment that are not paid by the insurance company (deductibles, services not covered, etc) will be billed to the patient by Associated Physicians of Southbury, PC for payment by the patient. The physicians will tell you about services they want you to have that are not covered by your insurances. Payment for these services are due the day the service is provided.

It is our policy to collect all copayments before your appointment.

I HAVE MY CURRENT HSA ON FILE: YES / NO

If you fail to cancel an appointment within 24 hours prior to the appointment time, you will be charged $35.00. If you miss your appointment for a physical exam you will be charged $100.00 for the appointment.

The copying fee for medical records is subject to state guidelines. Presently we can charge $1.00 per page and postage.

Minor patients: The copayment policy applies.

Insurance authorization:

I hereby authorize Associated Physicians of Southbury, PC to furnish information to insurance carriers concerning my illness and treatment.

I have read and understand the financial policy of this practice and I agree to be bound by these terms. I also understand and agree that such terms may be amended periodically.

_____ Date:_____
Signature of Patient or responsible party, if minor

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Please print name of Patient