#3 Medical Park Dr., Suite 201
Benton, AR 72015
Phone: 501-778-3361
FAX: 501-778-3135

GENERAL AND LAPAROSCOPIC SURGERY
JERRY DIXON M.D., F.A.C.S.

www.JerryDixonMD.com

PATIENT INFORMATION

Name:_____ Sex: ☐ Male ☐ Female
LAST FIRST MIDDLE
Date of Birth:_____ Age:____ Patient Soc. Sec #_____ Marital Status: ☐ **S** ☐ **M** ☐ **W** ☐ **D**
Address:_____
STREET APARTMENT # CITY STATE ZIP
Home Ph.(___)_____Cell Ph.(___)_____ Race/Ethnicity_____
Email Address_____

Patient's Employer:_____ Occupation:_____
Work Ph.(___)_____ Work Address:_____
Spouse's Name:_____ Occupation: _____
Spouse's Employer:_____ Work #: ( )_____Cell #: ( ) _____

IF PATIENT IS A MINOR, COMPLETE MOTHER AND FATHER INFORMATION:

Mother's Name:_____ Father's Name:_____
Address:_____ Address:_____
City, State, Zip:_____ City, State, Zip:_____
Employer:_____ Employer:_____
Home #: (___)_____Work #: (___)_____ Home #: (___)_____ Work #: (___)_____

IN CASE OF EMERGENCY, Name of relative/friend **NOT LIVING AT SAME ADDRESS:**

Name:_____Relationship:_____
Address: _____Home # ( )_____Cell # ( ) _____

Name:_____Relationship:_____
Address: _____Home # ( )_____Cell # ( ) _____

Did your doctor send you to our clinic? : Yes : No If yes , please list the doctor's name: _____
Who is your Primary Care Doctor? : Same as above or List name: _____

Insurance Information

Primary Company:_____ : PPO Plan : HMO Effective Date: _____
Insurance Company Address: _____
STREET SUITE# CITY STATE ZIP
Policyholder's Soc. Sec #: _____ Insurance Phone:( ) _____
Policy #: _____ Group #: _____
Policyholder's Name: _____ Birthday:_____ Sex: : Male : Female
Secondary Company:_____: PPO Plan : HMO Effective Date_____
Insurance Company Address: _____
STREET SUITE# CITY STATE ZIP
Policyholder's Soc. Sec #: _____ Insurance Phone:( ) _____
Policy #: _____ Group #: _____
Policyholder's Name: _____ Birthday:_____ Sex: : Male : Female

Insurance Authorization

I authorize the release of any medical information necessary to process my claim. I authorize payment of medical and surgical benefits to Jerry W. Dixon, MD. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature:_____ Date:_____

This is a confidential record: Please answer the following questions as completely as you can.
If you are uncertain about a question, leave it blank. Information contained here will not be released without your authority.

Date_____

Patient's Name_____ Age_____

Maiden Name or any other name used?_____

Referring physician's name_____ Phone_____

Primary care physician's name:_____ Phone_____

What symptoms/problems prompted this today? _____

_____

How long have you had this problem?_____ □Hours □Days □Weeks □Months□Years.

Does this problem cause you pain? □yes □no If yes, describe below:

Where does it hurt?_____

How does it hurt?_____

How severe is it?_____

When does it hurt?_____

What makes it hurt more?_____

What makes it hurt less?_____

Have you had any tests (lab, x-rays, etc.) for this problem? □ No □ Yes

If yes, which test, when was it done, and where was it done?_____

_____

PAST SURGICAL HISTORY □ No Prior Surgeries

	Date if known				
□ Appendectomy	_____				
□ Back Surgery	_____	□ Lower	□ Neck		
□ Breast biopsy	_____	□ Left	□ Right		
□ Breast Surgery	_____	□ Left	□ Right		
□ Colon surgery	_____				
□ Colonoscopy/EGD	_____	□ polyps			
□ Gallbladder	_____				
□ Heart	_____	□ Pacemaker	□ Bypass	□ Stents	
□ Hernia	_____	□ Left Groin	□ Right Groin	□ Umbilical	
		□ Incisional	□ Epigastric		
□ Hemorrhoidectomy	_____				
□ Thyroid	_____				
□ Hysterectomy	_____				
□ Tonsillectomy	_____				
□ Other surgery	_____				

Physician use only:

For Physician use only:

PAST MEDICAL HISTORY: Please check any that apply to you.

- ❑ Arthritis
- ❑ Back problems
- ❑ Bladder problems
- ❑ Blood clots in □ legs or □ lungs? Require blood thinners? □ Yes or □ No
- ❑ Blood transfusion
- ❑ Bleeding disorder
- ❑ Cancer? What type or where _____ Did you receive □ chemo □ radiation?
- ❑ High cholesterol or lipids
- ❑ Diabetes □ diet controlled □ on oral medication □ on insulin
- ❑ High blood pressure
- ❑ Liver problems □ Cirrhosis □ Hepatitis, type _____
- ❑ Lung problems □ COPD □ Tuberculosis □ Emphysema □ Asthma □ Sleep apnea □ Shortness of breath □ Other □ Lung cancer
- ❑ Mental health problems □ Depression □ Bipolar □ Dementia □ Other
- ❑ Nerve or neuro problems □ seizures □ migraines
- ❑ Stroke/TIA Any residual deficits? _____
- ❑ Thyroid problems □ on medication
- ❑ Coronary artery disease □ heart attack □ congestive heart failure □ arrhythmia
- ❑ Peripheral vascular disease
- ❑ Skin disorders □ psoriasis □ skin cancer – □basal □squamous □melanoma

FAMILY HISTORY: Do any of your blood relatives (parents, brothers/sisters, grandparents, aunts/uncles/cousins) have or ever had any of the following diseases?

□ None □ Unknown Family History

	Which Relative?
□ Cancer and what type	_____
□ Diabetes	_____
□ Heart Disease/ Problems	_____
□ High Blood Pressure	_____
□ Lung Disease/Problems	_____
□ Stroke	_____
□ Kidney Disease	_____
□ Blood Disease	_____

OCCUPATIONAL/SOCIAL HISTORY:

Birthplace: City _____ State _____

Educational Level: □ HS □ GED □ Some College □ Graduated College
Present Occupation_____
Martial Status: □ married □ single □ divorced □ widowed
Spouse's age_____Spouse's Occupation_____
Spouse's state of health: □ Good □ Fair □ Poor
What church do you attend?_____
Are you willing to accept Blood or Blood products in an emergency? □ No □ Yes
Do you smoke tobacco? □ No □ Yes _____packs per day for _____ years
Do you use smokeless tobacco products? □ No □ Yes What and how much?_____
Do you currently use any form of illegal substances? □ No □ Yes, type?_____
Do you currently consume any alcohol? □ No □ Yes
If yes, how often? □ Daily □ Weekly □ Socially
Type: □ Beer □ Wine □ Liquor

Patient's Name_____Date_____

REVIEW OF SYSTEMS Please check any of the following you **currently** or in the **last three months** have experienced.

Constitutional Symptoms:
□ None □ severe headaches □ dizzy spells
□ fatigue □ weakness
□ night sweats □ blood transfusion
□ sensitive to heat/cold
□ trouble with bleeding
□ marked weight □ gain □ loss
other_____

Eyes:
□ None □ trouble seeing □ eye pain/injury
□ cataracts □ wear glasses
□ wear contacts
□ blindness □ right □ left □ both
□ other_____

Ears, Nose, Throat, Mouth:
□ None □ frequent ear infection □ ringing in ears
□ snoring □ sore throat
□ sore mouth/gums □ hoarseness
□ frequent nose bleeds □ dental problems
□ sleep apnea □ use a pap machine
□ pain or difficulty swallowing
□ neck stiffness/swelling/lumps
□ wearing of dentures/partials/caps
□ hearing loss □ right □ left □ both

Breasts:
□ None □ lump(s) □ nipple discharge
□ fibrocystic disease
□ diagnosed with breast cancer
Do you perform monthly self breast exams?
□ Yes □ No
When and where was your last mammogram?
_____

Heart:
□ None □ irregular heart beat □ slow heart rate
□ rapid heart rate □ chest pain
□ palpitations □ pacemaker
□ heart attack □ fainting spells
□ congestive heart failure
□ other_____
Do you have a cardiologist?
□ No □ Yes: Name:_____

Lungs:
□ None □ persistent cough □ productive cough
□ pneumonia □ coughing up blood
□ shortness of breath □ tuberculosis
□ wheezing □ asthma
□ pulmonary embolus
□ other_____

Musculoskeletal:
□ None □ muscle cramps □ muscle weakness
□ generalized aches □ arthritis
□ disc disease □ fibromyalgia
□ joint swelling or pain □ joint stiffness
□ other_____

Gastrointestinal:
□ None □ constipation □ diarrhea
□ gallstones □ heartburn
□ hiatal hernia □ loss of appetite
□ nausea □ vomiting
□ vomiting blood □ black tarry stools
□ jaundice □ stomach ulcer
□ hemorrhoids □ rectal bleeding
□ change in bowel habits
□ other_____

Genitourinary:
□ None □ stress incontinence □ painful urination
□ kidney disease □ dialysis
□ frequent bladder infection
□ difficulty urinating
□ frequent urination □ blood in urine
□ other_____
Males only: Have you ever had a prostate exam?
□ Yes □ No
If yes, when was the last one?_____

Gynecological:
□ None □ irregular periods □ heavy periods
□ pelvic infection □ uterine fibroids
□ ovarian cyst
□ other_____

Skin:
□ None □ new or change in mole
□ skin ulcer
□ change/loss of hair
□ other_____

Endocrine:
□ None □ thyroid problems □ diabetes
□ other_____

Neurological:
□ None □ dementia □ migraines
□ TIA □ multiple sclerosis
□ depression □ seizures
□ anxiety □ sleeplessness
□ poor balance □ memory loss
□ paralysis □ Parkinson's disease
□ numbness □ frequent falls
□ other_____

Patient's Name_____Date_____

Name of person filling out paperwork_____Relationship to patient_____

MEDICATION RECORD

Please list all pharmacies that you currently use to fill your prescriptions.

You may use back of page if needed.

Name of Pharmacy_____ Name of Pharmacy_____

City_____ State_____ City_____ State_____

Pharmacy's Phone#_____ Pharmacy's Phone # _____

ALLERGIES

□ No known allergies □ Latex allergy □ Iodine/Shell Fish

Drug	Reaction

MEDICATIONS

(prescription, over the counter, herbal supplements, etc.)

□ No medications □ List copied and attached

Medication/Strength	Dose/Frequency	Reason for medication

I agree that Jerry Dixon MD may request and use my prescription medication history from other healthcare providers or Third Party pharmacy benefit payers for treatment purposes.

Patient's Signature: _____Date_____

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NOTICE OF PRIVACY PRACTICES

Effective Date: 09/01/1998
This Notice was most recently revised on 10/01/2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Janet Dixon
Mailing Address: #3 Medical Park Dr., Suite 201, Benton, AR 72015
Telephone: 501-778-3361
Fax: 501-778-3135
E-mail: janet@jerrydixonmd.com

About This Notice

We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?

Protected Health Information (PHI) is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI

We may use and disclose your PHI in the following circumstances:

For Treatment. We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclosure the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

Right to Inspect and Copy. You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in one or more designated record sets electronically (for example an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured PHI.

Right to Request Amendments. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are <u>not</u> required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-

month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. Your must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You can get a copy of this Notice at our website: http://www.jerrydixonmd.com

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

FINANCIAL POLICY

Insurance:

- It is your responsibility to provide us with the most current insurance information**.** Please bring your insurance card as well as your photo ID to your appointment.
- We do accept Medicare assignment, AR Medicaid, AR Kids, Tricare and participate with most insurance network plans. You will need to contact your insurance company to verify our doctor is in your particular network
- Some insurance plans require a referral from your primary care provider to be seen by a specialist. If your insurance plan does require a referral, you will need to bring it with you to your appointment.
- We will be happy to file with your insurance; however any co-pays, deductibles, co-insurance are due at your appointment. **Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.**
- It is unlawful to waive/fail to collect or discount co-payments, deductibles, coinsurance or other patient responsibility payments per the Federal False Claims Act, Federal Anti-kick Statue, and state and federal insurance fraud laws. It is also a violation of our managed care contracts. This includes services deemed as "Professional Courtesy".

Self-Pay/ No Insurance:

- **Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Billing Specialist.**

Billing Information:

- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- When you receive a statement, if you have any questions or dispute the validity of the balance it is your responsibility to contact our office within 30 days after receipt of the initial statement.
- Payment in full is due upon receipt of the statement. Patient balance not paid in full within 30-days of statement issue date is deemed past due. If the entire balance cannot be paid in full, our office can arrange a payment plan with monthly payments expected. Past due accounts may be referred to a professional collection agency. You will be responsible to pay all collection costs incurred.
- There will be a $25 fee for all returned checks.
- Failure to keep your account balance current may require us to cancel or reschedule appointments.

Surgery/Procedures:

- **Cancellation policy:** Out of courtesy to other patients, we require a 48 hour notice if you need to cancel your procedure or test. If there is not enough notice, you will be charged $50. By law, this charge will not be billed to your insurance. It will be your responsibility.
- We will request a pre-surgical deposit. The amount depends on your coverage and deductible and co-insurance amounts. If a deposit is needed (based on your policy), it is due 3 days prior to the scheduled procedure.
- It is your responsibility to call your insurance company to determine what procedures are covered within your particular insurance plan. Ex: wellness plans, pre-existing clauses, etc. **All non-covered services will be your responsibility.**

As part of our professional relationship, it is important that you understand your financial responsibilities. If you have any questions, please call our office at 501-778-3361.