Roberta L. Gartside M.D.
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Office Financial Policy

Effective June 27, 2019

This information is to inform you in advance of our office financial policies. This policy serves to provide a clear understanding of your rights and financial responsibilities. Please feel free to discuss any additional questions with our staff. We look forward to providing quality medical care to you and help in any way we can.

You agree to provide the office with complete, accurate, and up to date information. A valid insurance ID card, complete patient demographic form, and verification of eligibility and benefit coverage. You agree to authorize Roberta L. Gartside, MD, to release all necessary medical information to your insurance carrier necessary to complete payment of claims. You also authorize all medical benefits which are payable under the terms of your policy to be paid directly to Dr. Gartside.

All co-payments and deductible amounts are due and payable at the time of service per your contractual obligation with your insurance company. Payment in full is expected if you do not have insurance coverage, receive services for an uncovered benefit, or fail to furnish necessary insurance coverage documentation at the time of your visit. You understand that your insurance is a contract between you and your insurance company, not between your insurance company and the doctor. You are fully responsible for all medical fees. Please carefully review your health insurance coverage and benefit policies. Your Insurance Member Services Department can assist you in understanding your policy.

Payments and Fees Policy:

I agree and understand that I am personally liable to the medical service provider for payment of any balance on my account or on any account for which I am responsible as a parent or guardian (which may include professional service fees, missed appointment fees, bounced check charges, etc.) regardless of whether insurance benefits have been applied for or received, including interest on any outstanding balance(s) at the rate of 18% per annum accruing 30 days after services were rendered and for any and all collection costs or fees, including but not limited to, 40% attorney's fees and court costs if the account(s)is/are turned over to a third party and/or attorney for collection. I agree and understand that if I do not dispute in writing the amounts and charges set forth in any statement within 30 days after its issuance date, that I am agreeing that the amounts and charges set forth in any statements are fair, reasonable and accurate. I agree and understand that if I file an action/counterclaim against the medical service provider/practice and the medical service provider/practice incurs any costs and attorney's fees for its/their defense, I am liable for such costs and attorney's fees if the medical service provider/practice is the prevailing party in said proceeding, which shall include, but not be limited to, bankruptcy, arbitration, mediation, litigation or other processes.

We accept cash, checks, Visa, Master Card, Discover or American Express Card for payment(s)

- **There is a $50 fee for returned checks, plus the original amount of the returned check.**
- **There is a $25 fee for no show/missed appointments or failing to provide 24 hours advance cancellation notice.**
- **There is a $600 surgical rescheduling fee if you fail to provide a 14-day advance notice and valid medical excuse.**
- **There is a 20% non-refundable deposit required when scheduling any cosmetic surgery. This fee is applied towards surgery and is non-transferable.**
- **Office based procedures (insurance or self-pay) may have a practice management fee associated with them and you will be informed prior to scheduling.**
- **There is a $30.00 fee for any forms that Dr. Gartside needs to complete/sign. (FMLA, Disability, Time off Work)**

I, _____, certify that I have read, understand, and agree to all terms of the above office financial policy.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Printed Name/Name if Signed on Behalf of Patient Relationship (Parent, Legal Guardian, etc.)