Mayfair Internal Medicine, P.C.
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MISSED APPOINTMENTS

If I am going to miss an appointment, I understand that I must cancel 24 hours in advance. Otherwise, I may be charged a $30.00 cancellation fee for each missed appointment and $100 fee for eached missed complete history and physical.

PATIENT INSURANCE AGREEMENT

I understand that I must provide complete insurance information and a copy of my insurance card at every office appointment . I am responsible for ensuring this information is correct and effective at the time of service. If I don't provide this information I understand I am responsible for paying the entire bill .

ASSIGNMENT OF BENEFITS

I authorize my insurance benefits be paid directly to the physician. I will pay co-payments at the time of my appointment. I will pay non-covered services, co-payments, co-insurance and deductibles after the insurance company processes my claim(s) and Mayfair notifies me of my responsibility.

AUTOMOBILE ACCIDENT PAYMENT POLICY

I understand that legal delays and issues with insurance carriers do not eliminate my responsibility for the bill. Mayfair Internal Medicine will bill the insurance, but, if there is no payment within one month, I will need to pay Mayfair Internal Medicine immediately.

FINANCIAL AGREEMENT

If my check is returned by my bank for insufficient funds in my account, I will owe Mayfair Internal Medicine an additional $20.

I understand that co-payments are my responsibility and are due at the time of my office appointment. I understand that any bills must be paid within 30 days unless an alternative payment arrangement is made directly with our office manager. If I disagree with the balance due, I will contact Mayfair within 30 days of receipt of my statement to discuss how my bill will be paid.

If I have an unpaid balance 60 days overdue without an approved alternative payment agreement, I understand that I will be responsible for the following additional fees:

- **$10 monthly re-bill fee**
- **40% collection fees will be added to the unpaid balance turned over to an outside collection agency**
- **Re-billing and collection fees as described above apply to any past, current and future unpaid balances due to Mayfair Internal Medicine**

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Signature of Patient or Personal Representative **Description of Personal Representative's Authority**

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Print Name of Patient **Date**