THOMAS J. ASCIUTO, MD CORP

CANCELLATION POLICY

To ensure that all patients have access to timely care, we kindly ask that you provide at least 24 hours' notice if you need to cancel or reschedule your appointment. This gives us time to schedule other patients who may be waiting for an appointment.

If an appointment is missed or canceled with less than 24 hours' notice of your scheduled appointment, a $75.00 fee will be charged. The fee will be charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

We appreciate your understanding and cooperation in this matter. If you need to reschedule or cancel an appointment, please contact our office by phone (714) 861-4545 or email oclungdoctor@gmail.com at least 24 hours before your scheduled appointment to avoid this fee.

Multiple instances of No Shows or failure to pay may result in termination from the practice.

I acknowledge the No Show/Cancellation Policy and I understand and agree that I am responsible for any fees that may occur.

_____ _____

Patient Signature Date

THOMAS J. ASCIUTO, MD CORP

Billing & Financial Policy Information

- Your insurance company informs all participants that is ultimately your responsibility to verify benefits and coverage information prior to having any services rendered. Every attempt is made to comply with your insurance company's requirements. Since policies and benefits differ among employers and individuals participating with each insurance company, we are unable to know all the specifics of your policy. Thomas J. Asciuto MD Corporation cannot guarantee the cost of services preformed will be covered by your insurance.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. Please contact your insurance company with any questions about your benefits and coverage.
- Insurance companies require submission of all claims within specified time limits. If you have a change in your insurance and you fail to inform us of the change, we may not be aware until your insurance company denies a claim. Denials often arrive after the filing limits have expired, preventing us from re-filing the claim with another insurance. To limit the charges that you may be responsible for, please ensure that we always have up-to-date information regarding your insurance coverage.

You will be responsible for payment of all services if any of the circumstances apply:

- If you do not have insurance
- If you do not have a referral when required and have elected to be seen
- If you are with an insurance company that we are not contracted with
- If a claim denial from the insurance company is not able to be resolved

All payments are due within 90 days from the date of the first statement. If payment is not received within this timeframe, the account balance will be referred to an outside collection agency.

Co-payments are due at the time of service. Please ensure that payment is made at the time of your appointment. This arrangement is part of your contract with your insurance company. We accept cash, check, and credit cards.

By signing this form, I have read the financial policies listed above and agree to all the information, authorize the release of any medical information to necessary to process your claims, and authorize payment of medical benefits to Thomas J. Asciuto MD Corporation. My signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____
Signature of patient or responsible party

_____
Print Name

_____
Date

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Consent to Email or Phone Call Usage

Patients in our practice may be contacted via email and/or phone to remind you of an appointment and to provide general health reminders/information.

If at any time I provide an email or phone address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or phone address from the Practice.

_____ **(Patient Initials)** I consent to receive phone calls from the practice at my telephone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request will apply to all future appointment reminders & health information unless I request a change in writing (see revocation section below).

PHONE NUMBER (Authorized):_____

EMAIL ADDRESS (Authorized):_____

PATIENT SIGNATURE:_____

DATE:_____

REVOCATION (please "X" all that apply)

_____ I hereby revoke my request to receive any future appointment reminders and general health information via **email.**

_____ I hereby revoke my request to receive any future appointment reminders via **telephone.**

PATIENT SIGNATURE:_____ **DATE:**_____

PRACTICE REPRESENTATIVE SIGNATURE:_____