The SWICFT Institute
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FINANCIAL POLICY

Our charges for services are based upon the severity and complexity of your illness as well as the time spent treating you. In general, your initial visit will be more expensive than follow-up visits due to the collection of historical data and physical examination.

Payment for services rendered will be due at the time of service unless prior arrangements have been made. If you belong to a PPO insurance plan, etc. co-payments are to be paid at the time of service. We accept cash, check, Visa or MasterCard.

INSURANCE POLICY

Each patient must realize that professional services are rendered to you, not to your insurance company. Therefore, the insurance company is responsible to you, and you are ultimately responsible to us for professional service. We require insurance co-payment at the time of service. If you have no insurance, then payment is required in full, unless arrangements have been made.

Our services are covered by most PPO and other insurance plans. As each plan may differ, it is your responsibility to verify with your insurance company that our services will be covered before your appointment.

If you have questions regarding billing please contact our billing department at 239-325-2050

PAST DUE BILLS

If you currently have a past due balance on our account, the payment is expected in full prior to being seen by the Doctor. Payment arrangements my also be made for large balances. The patient will be responsible for contacting their insurance company if there is a dispute as to why they did not pay for services.

CANCELLATION POLICY

Our office requires 24-hour notification if the need to cancel your appointment arises. If this cancellation policy is not adhered to, the following action will be taken: First occurrence will prompt a warning reminding you of our policy. Second occurrence may result in a charge to you for the missed appointment. Please be aware that many insurance providers do not consider this as a covered expense in their plan, therefore you will be personally liable for this fee. Finally, it is our office policy to terminate medical services to patients who have missed appointments without 24-hour notification on three or more occasions.

I acknowledge that I fully understand the above statements and will comply with these policies.

_____ _____

Signature of Patient **Date**

_____ _____

Patient Name (Printed) **Date of Birth**