Tremont Medical Center, PA
Financial Policy

1. All charges incurred for services in the office are due and payable at the time service is rendered. The only exclusion to this policy will be those patients who are being treated for an authorized Worker's Compensation claim. The Employer or Worker's Compensation Insurance carrier for the Employer will pay the physician directly for services.

2. We are happy to provide treatment for work related injuries (Worker's Comp.). We will file insurance if we are provided with the information necessary to file the claim. If we are not provided with the necessary information at the time of service, the patient or employer will need to pay at that time and be reimbursed when we receive payment from the insurance carrier. Any charges incurred for this treatment are ultimately the responsibility of the patient if the claim is denied.

3. A **$25.00** service charge will be applied to your account for all returned checks.

4. Copying medical records for reasons other than our physician referring you to another physician will incur a cost of not less than $10.00. Cost is based on the number of copies and postage and handling.

5. If your account becomes past due, we will assess a $25.00 late fee after 60 days. We may also take steps through a collection agency to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs including a collections fee added to the account. If we send your account to collection because of non-payment, our physicians may no longer be able to provide care for you.

6. Once you have signed this agreement, you agree to all of the terms and conditions contained herein for this and any future visits, and the agreement will be in full force and effect for every visit.

7. I authorize the physician in charge to administer medical care as is necessary, including allowing release of x-ray and other medical reports on my physical condition to any party involved in my treatment.

Signature:_____

Printed Name: _____

Date:_____

A signed copy of this agreement will remain in your medical record