

Please read office
policy before signing

Please arrive 15 minutes
before your scheduled
appointment time

DR. CYNTHIA S. FERRELLI, D.P.M.
330 Harris Hill Road, Suite B
Williamsville, NY 14221

OFFICE POLICY

I am aware that acceptable forms of payment are: cash, check, or money order. **WE DO NOT ACCEPT CREDIT, DEBIT OR FLEX CARDS.** If I have Independent Health or Empire Plan insurance, I am to bring enough funds to cover 2 co-pays (one for your visit and one for x-rays, **if needed**). Since I am seeing a specialist, my co-pay may be higher than when seeing my primary care physician and this is not always specified on my card. Additional funds may also be needed to purchase medical supplies which are **NOT** covered by insurance.

If my checking account has insufficient funds, I will incur a \$20 service charge.

I must have my insurance card at my visit or a copy of the front and back. Handwritten information off the card is not acceptable.

Co-pays are due prior to entering the treatment room area. If I do not have my co-pay(s), my appointment will be rescheduled.

If I require a referral with my insurance, I am responsible for obtaining one from my primary care physician. If I do not have a referral, my appointment will be rescheduled.

I realize that I may have a health insurance deductible that needs to be met first before my medical services are covered.

The office usually provides a courtesy reminder call when your appointment is approaching. It is my responsibility however, to keep track of my appointments. Do not rely solely on this phone call.

I realize that I am responsible for my health insurance coverage and despite the fact that I may inadvertently receive incorrect information, or misinterpret information, I am still solely responsible for any noncovered fees.

I authorize the release of any medical information about me to the proper agency to determine medical benefits. I authorize payment of medical benefits to be made directly to Dr. Cynthia Ferrelli and accept responsibility for any remaining balances not covered by my insurance.

I have 30 days to pay any balances. After this, I will be charged a \$1.50 service charge each month for late payments. After 2 billing cycles without payment, my account may be sent to the collection.

I agree to pay the \$40 fee incurred for any missed appointments (barring an emergency) in which I do not notify the office 24 hours in advance. You may leave a voice mail message. If not paid within 14 days this will be sent to collection.

Signature

Date

Please note: Due to NYS OSHA Regulations, children are not allowed in treatment rooms unless they are the patient.

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