ANDREW L. SIMON, M.D., F.A. C.S.
459 Jack Martin Blvd #3
Brick, NJ 08724

FINANCIAL POLICY (Updated 2017)

We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company. Your doctor's bill for the services provided to you is an agreement between you and your Doctor. You are personally liable for all balances not covered by your insurance.

PAYMENT in full is expected at the time of service unless you are covered by an insurance carrier in which Dr. Simon is considered a participating provider. You are responsible for deductibles, co-pays, non-covered services, coinsurance, items considered **"non** medically necessary" by your insurance company as well as other charges you may incur for services rendered by us. It is your responsibility to understand and comply with all the terms of your insurance contract including predetermination of benefits or referral requirements.

CO-PAYMENTS: Payment for co-pays is expected at the time of service. No exceptions.

RETURNED CHECKS: A $25.00 fee will be charged for all checks that are returned for non-payment.

REFERRALS: Many insurances require a referral from your Primary Care Physician. It is the patient's responsibility to know if a referral is needed and to obtain the referral prior to the time of service. If a referral is not presented at the time of service, the patient will either be rescheduled or will be responsible for payment in full for that service at the time of service.

INSURANCE: As a courtesy, we will submit your claim to your secondary carrier if it does not automatically cross over from your primary insurance. **We DO NOT bill third** insurance.

PAST DUE ACCOUNTS: I agree to be financially responsible for the charges for these services. If my account is assigned to a collection agency, I agree to pay all collection fees of 25%, court costs and reasonable attorney fees. I understand that all accounts with a balance over 60 days will be assigned interest at the rate of 16% annually on the unpaid balance.

COMMUNICATIONS WITH YOU AND CONSENT TO CONTACT YOU

By providing a wired and/or wireless telephone number you agree, in order for us to service your account or to collect any amounts you may owe, we, our agents, assignees, third-party(s) servicing agent(s) or a third-party debt collector may contact you by telephone at any telephone number associated with your account and/or number provided by you, including but not limited to wired or wireless telephone numbers, which could result in charges to you. You also agree to allow us, our agents, assignees, third-party(s), servicing agent or third-party debt collectors to communicate with you to include text messaging, email, facsimile and any other electronic communications. You also agree that methods of contact may include the use of pre-recorded/artificial voice messages and/or use of an automated telephone dialing device or system, as applicable. You agree that we, our agents, assignees, third-party(s) or servicing agent(s) and third-party debt collectors may, for training purposes or to evaluate the quality of service, may listen to and record phone conversations you have with us and/or our agents, assignees third-party(s) or servicing agent(s) or third-party debt collectors.

We accept cash, checks, money orders, Visa and MasterCard.

I have read the Financial Policy, Assignment and Release of Information paragraphs stated above. I understand and agree to the above.

Print Name	Signature	Date

A COPY OF THIS NOTICE WILL BE FURNISHED UPON REQUEST