Brighton Family Medicine, LLP
945 E. Henrietta Road
Rochester, NY 14623

Laura Booth, M.D. Christine C. Borghi-Cavallaro, M.D. Jerold Desimone, RPA

PAYMENT POLICY

With all the new insurance plans created each year, more patients have opted to go with low/high deductible insurance plans. We will be collecting partial payment toward your visit at the time of service. This also includes self-pay patients. Many offices in the community also implement this policy. Patients with co-payment plans will still be responsible for their co-payment at the time of their visit.

If you are scheduled for an appointment and your deductible has not been met, you will be asked to pay $80.00 toward your deductible for your visit that day. We will bill you for any remaining balance after your insurance processes your claim. The $80.00 will not go toward any past due balances, which also need to be paid at the time of your visit, unless prior arrangements were made. The $80.00 payment will not be necessary for a visit that your plan covers as 'preventative care,' which is usually defined as a complete physical and/or gynecologic examination. Understand that complete physical examinations are performed no more frequently than once per year, and chronic medical problems cannot be managed in only one visit per year. Therefore, please come prepared to comply with this payment policy.

If payment is not made on day of service, for either your copay or your payment toward your deductible, there will be a $10.00 service charge placed on your account.

In the unlikely event of an overpayment, a refund will be issued. Refund checks will be processed monthly.

Please feel free to call our Office Manager at 292-6440 X 102 if you should have any questions regarding this policy.

We would like to thank you for your understanding and cooperation.

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ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

Patient Name: _____ DOB: _____
(Please Print)

I acknowledge this document as a legally binding assignment of benefits to collect payment from my insurance carrier for services provided by Brighton Family Medicine, LLP. In the event my insurance carrier makes payments directly to me, I will endorse such payments to Brighton Family Medicine, LLP. I authorize my insurance carrier to release information regarding my coverage to Brighton Family Medicine, LLP. I authorize Brighton Family Medicine, LLP to obtain and/or release any medical records necessary to my physician(s), attorney(s), insurance company(s), including Medicare and/or their representatives. I also authorize payments of medical benefits directly to my physician and agree to accept responsibility for any charges denied by my insurance company. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, I will be fully responsible for all collection agency fees and attorney's fees. I have read tis and accept the terms.

_____ _____
Signature of patient or other authorized person Date
(If other than the patient, please indicated relationship to patient)

NOTE: There is a $10.00 service charge for non-payment of same day co-pay/deductible

NOTE: There is a $30.00 service fee for any returned checks

NOTE: There is a $50.00 No Show fee if you fail to give us 24 hours advance notice when cancelling. This fee is not covered by insurance. It is the personal responsibility of the patient (or in the case of a minor, the parent).