D'nese Sokolowski, MD, FACOG, PC

2895 Hamilton Blvd, Suite 204
Allentown, PA 18104
Phone (610) 391-9180 Fax (610) 841-0459

Thank you for choosing Dr. Sokolowski as your ob/gyn. Please take a moment to review our financial policy.

- We accept cash, check or credit cards
- Copayment is due at the time of office visit

Insurance

Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will gladly process your claim, but we request your portion be paid at the time of service. To do so, we require your complete and current insurance information. In the event we do not accept assignment of benefits, please know that the balance of your bill is still your responsibility whether your insurance company pays or not. Regarding insurance plans in which we are participating, please understand we do require payment of co-pays and deductibles prior to treatment. You may be additionally responsible for any non-covered services or any services considered "not medically necessary". If your insurance company has not paid your account in full in 30 days, you will have 30 days to arrange payment of the balance due. Late fees will accrue monthly. If balance remains unpaid for 90 days from date of service, accounts will be placed with Hamilton Law Group, PC for collection. You will be responsible for interest of 1.5% per month (18% per year) and for collection attorney fees of 40% on the unpaid balance and interest.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The patient is responsible for any unforeseen fees levied by outside institutions due to return or reversal of payment (not to exclude returned checks, credit card chargebacks or fraudulent charges). There is a fee for all missed appointments and those cancelled without 24 hours (one business day) notice: $75/$50 for new patient/established patient appointment.

Insurance Authorization and Assignment

I request that payment of authorized insurance benefits be made on my behalf to *D'nese Sokolowski, MD* for any services furnished to me. I hereby authorize this office to release any medical information necessary to process my claim.

I have read this financial policy. I understand and agree to this policy.

______________________________	X______________________________	______________
Printed Name	Signature of Patient/Responsible Party	Date
______________________________	X______________________________	______________
Parent/Guardian if patient under 18	Signature	Date

For Medicare Patients Only:

I request that payment of authorized Medicare benefits, and any Medicare supplement benefits to which I subscribe, be made on my behalf to the physician for any services furnished to me by the listed physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

______________________________	X______________________________	______________
Printed Name	Signature of Patient/Responsible Party	Date