MARIO G. GIORGIANNI, M.D.

FINANCIAL POLICY

The following is a statement of our Financial Policy, which you are to read and sign prior to receiving treatment. We accept cash, checks, and credit cards for payment.

Insurance and Private Pay: I am not contracted with private insurance carriers. You will be responsible for payment of services at the time of your visit. Please talk with us if you have any questions or concerns regarding our fees or payment for services.

Arrangements for Payments: Our charges for services are in line with what is usual and customary for this area, and if requested, will be provided to you. Our policy is to provide care to patients regardless of the ability to pay for services. If it is agreed prior to the initiation of care, that a financial hardship restricts your ability to pay standard fees or co-pays as noted above, an extended payment plan without interest may be arranged. Please talk with us, if you need to arrange a payment plan for your bill.

Missed Appointments: We make every effort to notify you in advance of an upcoming visit. Cancellation of an appointment must be received at least 48 hours in advance of your appointment; otherwise, you will be charged a cancellation fee of $100 for a consultation visit and $50 for a follow up visit.

Medicare Patients: As a Participating Provider with Medicare, I agree to accept the allowed amount from Medicare as the full charge. You will be responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the allowed amount paid by Medicare. Please read and sign the following:

> "I request that payment of authorized Medicare benefits be made on my behalf to Mario G. Giorgianni, M.D. for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on submitted claims, my signature authorizes releasing information to the insurer or agency shown."

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Patient Name Date

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Signature of Patient or Responsible Party