



Financial Policy

The patient, guarantor, parent, or guardian is responsible for payment of services at the time of the office visit, test, procedure, or product purchase.

Insurance. Our office participates with many insurance plans, including Medicare. Our staff can provide limited information and assistance for each individual insurance plan. Every patient is responsible for individual coverage and benefits. A valid ID and updated insurance card is required. Certain insurances require a referral from your primary care provider, which is the patient's responsibility. All referrals are required prior to each service rendered. Patients are responsible for any non-covered services. If our providers are out of network (not contracted with) your insurance plan, the patient is responsible for all payment at the time the service is rendered.

Product Purchase. All products purchased in the office or through our online links are final sale and non-refundable.

Surgery Fees. Surgery may be performed at an ambulatory surgery center, hospital, or office procedure room. For insurance-covered surgery performed at an outside facility, separate claims may be submitted for surgeon, facility, and anesthesia services, as applicable.

Cosmetic Deposits and Refunds. A deposit of 20% of the surgical fee is due at the time of scheduling, and the remaining total balance is due 14 days before surgery. An amount equal to 10% of the deposit covers scheduling and processing costs and is non-refundable at any time. If you cancel or reschedule more than 14 days before surgery, the remainder of the deposit is refunded. If you cancel or reschedule within 14 days of surgery, the entire deposit is retained, whether or not the balance has been paid. If the surgical fee has been paid in full, the full fee may not be refunded. These amounts reflect reserved surgical time that cannot be reassigned on short notice.

Payment. Payment is due at or before the time services are rendered, including applicable copayments, deductibles, coinsurance, non-covered services, and other patient-responsibility amounts. We accept personal check, wire/ACH transfer, and credit card. We do not accept cash. Returned checks are subject to a \$25 fee, and additional transaction fees may apply where permitted.

Credit Card on File. A valid credit card is required to be kept securely on file. By signing this policy, I authorize Jennifer Murdock MD, PLLC to charge the card on file for outstanding patient-responsibility balances and applicable administrative, cancellation, or no-show fees in accordance with this Financial Policy. Card information will be stored securely and kept confidential in accordance with applicable privacy and payment-security requirements. Insurance will be billed when applicable before the card is charged for amounts that require insurance adjudication. Patients will receive an itemized statement or electronic notification of outstanding charges before their card on file is charged, except for previously disclosed cancellation or no-show fees.

Cancellation Policy. Please call our office as soon as you know you cannot keep an appointment or procedure. This policy applies equally to all patients. These charges are for reserved time that cannot be reassigned, not for the service itself, and are billed to the patient rather than to insurance. A \$50 fee applies if a clinical appointment is not cancelled or rescheduled at least 48 hours in advance, and \$200 if cancelled within 24 hours or missed. A \$500 administrative fee applies to any surgical cancellation, reschedule, or failure to appear within 48 hours of the scheduled date, whether insurance-covered or self-pay. The cosmetic deposit terms above also apply.

PATIENT FINANCIAL OBLIGATION AGREEMENT

I understand that all applicable copayments, deductibles, and fees are due at the time of service, and I agree to be financially responsible for charges not covered by my insurance. I authorize all health plan and insurance benefits to be paid directly to Jennifer Murdock, MD, PLLC, which may pursue collection of such benefits or unpaid balances in my name or its own. I authorize representatives of the practice to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim or fee. I authorize the practice to retain my credit or debit card on file and to charge it for the amounts described above, and I understand I may revoke this authorization in writing. I have read and understand the cancellation, deposit, and refund terms, including those that apply when a surgical fee has been paid in full. A photocopy or electronic copy of this agreement is as valid as the original. I acknowledge that I have provided a copy of this Financial Policy.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

NAME ON CARD ON FILE (if different): _____