PAYMENT POLICIES

Payment is requested at the conclusion of every appointment and our office accepts cash, personal checks and credit cards. As a reminder, our Administrative & Billing form states that patients agree to pay accounts within 30 days following the date of the scheduled appointment or payment invoice. Acccounts with balances exceeding 30 days will be charged 1.5% interest per month. Accounts with balances more than 3 months past due will be turned over to a collection agency and reported to credit bureaus. Checks returned by the bank will be charged a $35 fee. A credit card will be held on file to guarantee payment.

Failure to provide 24 hours cancellation notice and missed appointments will be charged at full fee. This time slot has been saved for you. It is the patient's responsibility to keep track of appointments., however, If an email reminder of appointments is needed, please provide your email address below and we will make every attempt to provide a reminder. Emails should not be considered as a method of communication for patient care as emails will not be checked by your physician.

Telephone calls are recognized as patient care by the American Medical Association and at times replace the need for an office visit. Telephone calls, document preparation and other requirments of Dr. Emch's time and expertise lasting longer than 5 mintues will be charged in five minute increments and prorated at an hourly rate of $225.

CREDIT CARD INFORMATION

I, ___________________________________ have read the above payment policies and authorize Douglas Emch, MD to charge my credit card for outstanding balances on my account due to late cancellations, missed appointments, returned checks, and past due accounts. My credit card will be held on file to guarantee payment within 30 days unless other payment arrangements are made.

Name on Card ___________________________________
Credit Card Type (circle one) Visa MasterCard Discover
Credit Card # ___________________________________
Expiration Date ___________________________________
Security Code ___________________________________
Street Address for credit card billing ___________________________________
Zip code for credit card billing ___________________________________
Signature ___________________________________
Date ___________________________________
Email address ___________________________________

EMAIL COMMUNICATION

I, ___________________________________request to receive email appointment reminders and information regarding my account balance from Dr. Emch's office. I understand that email should not be considered as a method of communication for patient care.

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