PATIENT FINANCIAL POLICY

John P. Muffoletto, M.D.
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(907) 276-1046

In order to continue to provide the level of medical services, which you my patient expect from this practice, I have adopted the following financial policy. I hope that this policy will help avoid any misunderstandings between my patients and the practice. If you have any questions about this policy, please discuss them with the Patient Account Manager. I am dedicated to providing the best possible care and services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Since this office will not be billing insurance for your account, full payment for your initial visit is expected at the time of service. Furthermore, with any elective surgery at least 50% of the total amount of the surgery will be expected before surgery can be scheduled. **Minimum monthly payments of $100.00 are due by the 15th of every month thereafter until your balance is paid in full.** _____
initial

If you were originally admitted or seen in consultation by Dr. Muffoletto in an in-patient hospital setting, **minimum monthly payments of $100.00 are due by the 15th of every month thereafter until your balance is paid in full.** _____
initial

Please note that we do not follow any financial plans that you may agree to with any hospitals or other medical facilities.

Accounts that are past due will be considered for and turned over to an outside collection agency and reported to the Credit Bureau. Accounts that have statements returned with no forwarding address will be turned over to a collections agency.

I know that you as a patient have a choice on where to receive your medical care. I appreciate you having selected me for your care. Please do not hesitate to contact any of my professional staff members if we can assist you in any way.

I have read and understood the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party (if patient is a minor) Date

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Please Print Name of Patient