

Edward Ruiz, M.D., P.C.

Office Policy

The patient is responsible for payment of services rendered by our practice. Co pays are due at the time of service. The office only accepts checks or cash. There will be a \$25 charge for a returned check. . **No credit, debit, or health savings cards are accepted.**

Our office will submit a claim to your insurance company. If we have not received payment from your insurance company after 90 days, we reserve the right to bill you directly, and, then expect payment within 30 days.

Some procedures are considered cosmetic and can not be billed to the insurance carrier. If your procedure is considered cosmetic, Dr. Ruiz will discuss this with you prior to the procedure. If you decide to continue, full payment is expected on the date of service.

At times, a biopsy specimen or culture may be sent to an outside lab. That facility will bill you directly. Blood drawing and lab testing is not done at this office. Please go to a laboratory or physician’s office that is covered by your insurance.

HMO insurance holder:

All HMO insurances require a specific referral in order for your visit to be reimbursed. It is the responsibility of the patient to make sure a referral is received, specific for the scheduled services, and not yet expired. **If your referral is not in this office on the date of service the appointment will need to be rescheduled.**

Please read carefully and sign below (either patient or parent/legal guardian):

I authorize insurance benefits to be paid directly to this practice.
I authorize the release of medical and insurance information to my health insurance carriers, laboratory/pathology facilities, and referring physicians.
I acknowledge that I have been given the opportunity to review and receive the Notice of Privacy Practices. (HIPAA)

I understand that the initial visit is for consultation & evaluation only. No surgery will be performed on that day.

I have read the above office policy and agree to abide by it, in its entirety.

Patient Name (please print)

My medical information may also be disclosed to the following person(s):

I.e: spouse, family member, etc (optional) Relationship

Signature: _____ **Date:** _____

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