1 CP Place PLLC
Office and Financial Policy

Thank you for choosing 1 CP Place PLLC as your medical provider. We require that you read and sign this document prior to any treatment. The policies stated in this document are subject to change at the sole discretion of 1 CP Place PLLC.

Insurance

Please bring your insurance card with you to your appointment. Co-pays and deductibles are due at the time of service. You are responsible for any non-negotiated coinsurance, deductibles, or services that are not covered by your insurance. You will receive a mailed statement from our office detailing all insurance payments for your visit. The remainder of your balance, if any, is due upon receipt.

Referrals

If your insurance requires a referral from your primary care physician before receiving services from a specialist, you must obtain and provide our office with the referral prior to your appointment.

No Insurance

Payment for all professional services is due at the time of your visit. Please contact our office for assistance.

Returned Checks / Delinquent Accounts

There is a $35 charge for all returned checks. Any delinquent accounts must be paid before any future appointments will be scheduled. Please contact us if you require a special payment arrangement and we will do our best to help you.

Cancellations / Rescheduling / No Show

If you are unable to keep your scheduled appointment please notify our office by phone or email within 24 hours of your appointment. If you do not notify us in advance to missing your appointment it is considered a No Show. *No Shows place a significant financial strain on our practice*, and are therefore subject to a $50 charge. Repeated No Shows will result in the patient being released from medical care, including refusal to approve any further prescription refills.

Late Arrivals

Please notify us as soon as possible if you are going to be late to your appointment. Since a late arrival can affect other patient appointments, we reserve the right to cancel and/or reschedule your appointment if you are more than 10 minutes late to your appointment. We will, however, do our best to accommodate you if the schedule permits.

By signing below, you acknowledge that you have read and agree to the policies stated above and that you agree to be responsible for any financial balance not paid for or negotiated by your insurance.

_____ _____

Patient / Parent / Guardian Signature Date

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