DMS
Obstetrics & Gynecology
Diane M. Sanfilippo, MD

Dr. Diane M. Sanfilippo
410 Abbott Road
Buffalo, NY 14220
Main: 716.827.4850
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www.dmsmd.com

The PATIENT acknowledges and agrees to pay the OFFICE fees listed below when indicated. The PATIENT may request a review or waiver of these fees. All requests for waivers must be in writing.

No Show for Appointment	*WITH DOCTOR	$ 100.00
No Show for Appointment	*WITH NURSE PRACTIONER	$ 50.00
Late Appt. Cancellation	24 HOUR NOTICE REQUIRED	$ 35.00
Surgery Cancellation	ONCE SCHEDULED	$ 100.00
Insufficient Funds	NSF Check, ACH Reversal	$ 35.00
Forms	FMLA, DBL, Other	$ 15.00 (each)
Copies	Medical Records	$ .75 (per page)

The PATIENT acknowledges and agrees to pay the OFFICE retainer fees and deductible amounts listed below when indicated. The PATIENT may request a review or waiver of these fees. All requests must be in advance and in writing. If unable to authorize a waiver of office billing policies, you will be notified in person, or by first class mail.

Maternity Care and Delivery	RETAINER	$690.00*
Maternity Care and Delivery	DEDUCTIBLE PLANS (25-50%)	Varies*
Hospital Surgery and Care	RETAINER	$225.00*
Hospital Surgery and Care	DEDUCTIBLE PLANS (25-50%)	Varies*
Outpatient Surgery and Care	RETAINER	$125.00*
Outpatient Surgery and Care	DEDUCTIBLE PLANS (25-50%)	Varies*
"Buy and Bill" Pharmacy Products	IUDs, DEPO, Etc.	Varies*

My electronic signature acknowledges that I have read and understand the terms, conditions, and patient billing policies of Diane M. Sanfilippo, MD OB-Gyn PC. I understand Dr. Sanfilippo is solely authorized to grant a waiver of the company policies.

Medical Care Billing Policies / Acknowledgement of Fees

This form may not apply to you if you have a Medicare or Medicaid based insurance coverage.

I, the **"PATIENT",** acknowledge receipt of Diane M. Sanfilippo MD OB-Gyn PC, the **"OFFICE"**, billing policies, accepts the terms, and wish to establish or maintain my relationship with Dr. Sanfilippo.

The OFFICE will process all medical claims to insurance carrier(s) with information provided by the **PATIENT.** The **OFFICE** may request payment of all **PATIENT** copayments, coinsurances, and deductible amounts at the time of service, or during an obstetrical or surgical billing period.

If **PATIENT** requests obstetrical care, surgical care, or certain pharmacy products the **OFFICE** may request payments, or a retainer fee, in advance based on specific insurance and benefit review circumstances. The **OFFICE** will refund all unapplied **PATIENT** payments and retainer fees within 30 days of settlement by the insurance carrier.

The OFFICE reserves the right to request all amounts due from the **PATIENT** at the time of requesting care or arriving for an appointment. The **OFFICE** reserves the right to request payment from the **PATIENT** at any time for up to two years (730 days) after the date of service. The **OFFICE** will mail statements to, and or call, the addresses and phone numbers provided by the **PATIENT** if a balance over $10.00 exists.

The PATIENT must request a Payment Plan if unable to pay full amount due within 30 Days.

The PATIENT acknowledges the following fees that may be incurred and agree to pay these fees to cover the additional OFFICE expenses.

STATEMENT FEE:	$ 5.00 (Waived for APPROVED Payment Plans)	
PRE-COLLECTION FEE:	$ 20.00 (COLLECTION PENDING LETTER)	
COLLECTIONS:	35% of Balance (ADDED BY AGENCY)	**Initials** _____

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Print Name: _____ **Signature:** _____

Witness Signature: _____ **Date:** _____