The Retreat
Dr Roxana M Stoici MD
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Financial Policy

Thank you for choosing **The Retreat/Dr. Stoici** as your health care provider.
We are committed to quality patient care at the lowest possible cost. The following is a statement of our financial policy that we require you to read and sign prior to any services being rendered.

Please be aware that some, and perhaps all, of the services provided may be not covered services that are not considered reasonable and necessary by your insurance carrier.

Participating insurance plans
For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. To properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event that your insurance coverage changes to a plan with which we do not participate, refer to the following paragraph.

Nonparticipating plans
For those plans with which we do not participate, we do not accept assignment of insurance benefits and we do not bill your insurance company. {Payment by cash, check or charge (Discover, VISA, MasterCard) is expected at the the time of service.}. Your policy is a contract between you and your insurance company.

Minors
A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit). An unaccompanied minor will be denied non-emergency treatment unless charges have been pre-authorized to an approved credit plan or insurance plan.

Authorization to pay benefits to physician/clinic
I hereby assign payment directly to **The Retreat/ Dr. Stoici** for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the clinic (not to exceed my indebtedness to the clinic for those services). I understand that I am financially responsible for charges not covered by my insurance.

Authorization to release information
I hereby authorize **The Retreat/ Dr. Stoici** to release any information acquired in the course of my examination or treatment to my referring physician and/or my insurance company.

Acknowledgement
I have read and understand the above Financial Policy and Benefit Authorization and agree to all provisions outlined herein.

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Signature of patient or responsible party Date