Thomas E. Bowser, M.D., PLLC
4105 Briargate Parkway, Suite 105
Colorado Springs, CO 80920
Office (719) 637-8444 Fax (719) 638-8286

FINANCIAL POLICY

Dear Patient,

Welcome to Thomas E. Bowser, M.D., PLLC. We hope the following information answers many of your questions regarding our policies on your insurance and the changes you will incur here. If you have any questions please call (719) 637-8444 and ask for the billing department.

As a courtesy to our patients we will bill your insurance company for you. However, each insurance company may have different requirements that we are unaware of. It is your responsibility to know your own insurance companies' requirements. We do not participate with some insurance companies. Please verify with your insurance company that Dr. Thomas Bowser is participating with your insurance.

Patients with insurance we participate with:
If your insurance requires a referral, it is your responsibility to make sure you have prior authorization for your visit and/or procedure during that visit. If you insurance requires a co-pay, that will be required at the time of the visit. Patients may be rescheduled if co-pays cannot be made.

Patients with insurance that we do not participate with:
If your insurance company does not pay within 60 days of the date of service, you will receive notice of this. Your will be expected to pay your account in full at that time. It is possible that you will be required to pay the full amount prior to your visit.

Patients without insurance:
You are required to pay in full for each visit at the time of service. If payment can not be made your appointment may be rescheduled.

WE ACCEPT CHECK, CASH, VISA, AND MASTERCARD FOR YOUR CONVENIENCE.
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Release of information:
I herby authorize the release of medical records and/or statements of accounts to my insurance company in order to determine benefits for services rendered.

Assignment of benefits:
I herby authorize payment directly to Thomas E. Bowser, M.D., PLLC. This instruction to you is an assignment of my rights under my medical coverage and therefore acts as a "signature on file" for all billing and insurance purposes. I state and agree that a photo static copy of this document shall be considered as effective and valid as the original for all parts of this contract. This authorization shall be valid for one year from the date of my signature.

24 Hour Appointment Cancellation Policy
There will be a $35 fee for missed appointments or appointments cancelled less than 24 hours in advance. Appointments may be rescheduled once this has been paid.

I AGREE TO BE PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF THIS ACCOUNT

Signature: _____ Date: _____

There will be a $25.00 service charge for all returned checks