Richard G. Quist, M.D.

Financial Policy

I am committed to your treatment being successful. The following is a statement of my . Financial policy, which you are required to read and agree to prior to any treatment.

Insurance Billing:

Your insurance policy is a contract between you and your insurance company. **It is your responsibility to know your benefits and how they will apply to your treatment.** I am not a party to that contract. If your insurance has not paid your account if full within 90 days, the balance will be transferred to you and/ or the guarantor listed on the patient information form. For your convenience I accept CASH, CHECKS, VISA, and MASTERCARD.

Cash Patients:

All services must be paid in full at the time of service. Please make arrangements with the billing dept. @ 714-527-1082 to get the amount you will need to bring in prior to your appt. or procedures.

Administrative Fees:

All co-pays will be collected at the time of service, prior to seeing provider. If co-pay is not paid patient may not be seen.

There is a $25 charge for all office appointments not cancelled or rescheduled @ least 24 hrs. in advance.

There will be a $200 per procedure not cancelled or rescheduled @ least 120 hrs. in advance.

All medical record requests are subject to a preparation fee of $25. The actual cost of shipping and handling will be added if applicable.

A fee or 25 will be applied to all checks retuned for insufficient funds.
Disability, Worker's Compensation, Employer leave, and other Administrative forms. These forms will not be mailed or returned until the fees are paid.

Procedures:

The physician charges only for the professional services provided by your physician. The Facility, Anesthesiologist, and Pathology departments will be billing your insurance directly.
There is a potential of four separate bills associated with procedures. Please be aware of this so there are no surprises after the procedure is performed.

I hereby attest that the insurance information I have provided is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage.
I will be financially responsible for all charges that are not covered by my insurance company.

Patient's Signature:_____ Date:_____