iCONMED Patient Agreement

Thank you for choosing iCONMED for your medical care. We ask that you agree to the following regarding payment for services rendered.

1. **Services are paid IN FULL at the time of service by cash, check or credit card (Visa , Master Card or Discover), before leaving the clinic.**

2. If you miss a scheduled appointment more than twice, you will have to prepay to make a new appointment to see Dr. Walters. We ask that you be considerate of others. If you are unable to make your appointment, please call 24 hours in advance.

3. If you leave the clinic prior to paying for any service, a $20.00 billing fee will be added to your charge and you will be billed accordingly.

4. If you decide to use your insurance for any outside testing for laboratory services or any imaging services, the office **WILL NOT** have any contact with your insurance if the service is not paid for. We **will not** send office notes, call for prior authorizations or fill out any forms for your insurance company. We are an out-of-pocket practice and do not take any type of insurance. We will provide you with a superbill should you wish to submit a claim to your insurance company.

5. Medicare and Medicaid patients are asked not to submit their office visits to those insurance carriers. Dr. Walters has opted out of all government programs and is not a Medicare or Medicaid provider.

6. Some medications are sold at the office for your convenience. You will not be able to get a refill of that medication before the refill date. If you lose, break or have medication stolen from you, we are not obligated to give you a new prescription. You will need to wait until the due date for that medication. If you are having another person pick up your medication they will need to have a payment on hand and they will need to provide us with a copy of their driver's license.

7. A $25.00 Returned Check fee will be charged to your account for any returned check.

8. If payment of balance due is not paid in full when requested, and collection actions are initiated to collect the amount due, a finance charge of 15% per month of the unpaid balance, will be added to your account.

9. ***Refunds will not be made on any pre-paid medical programs; any supplement, any durable Item or any prescription product purchased from this office.***

10. The office can mail your prescription to you if you live out of town/state. That charge will be $45.00 for overnight shipment and $20.00 for ground shipment.

I, _____ have read and understand the above
(Printed Name)
statements and agree to the above terms.

Signed:_____ Date:_____