Premier HealthNet
Premier Health Partners

Gem City
Surgical Associates
9000 N. Main St.
Suite 233
(937) 832-9310
(937) 832- 8613 Fax

Walter A. Reiling, MD, FACS
Thomas A. Heck, MD, FACS
James E. DeCaestecker, DO, FACS
Jennifer Z. Wu, MD
Michelle R. DeGroat, MD

Providing quality medical care for patients is our PRIMARY concern. However, in order to accommodate the needs and requests of our patients, we have enrolled in numerous insurance programs. We are more than willing to provide care within your insurance contact guidelines; however, you need to make us aware of those guidelines at each visit.

If your insurance carrier requires an authorized or referral from your primary care physician for each visit, it is your responsibility to obtain the referral prior to your appointment. If you have not informed us of any special requirements in regards to your insurance, and we order additional services such as lab work, special testing or surgical procedures, it will become your responsibility if your insurance company does not pay such services.

<u>IF PRE-CERTIFICATION IS REQUIRED, IT IS YOUR RESPONSIBILITY TO NOTIFY US.</u>

If surgery has been scheduled and is cancelled or rescheduled, you will be charged a $150 cancellation fee unless our office determines it was a valid reason.

If you need to cancel an office appointment, please do so with at least 24 hour notice. If we are not given a 24 hour notice, we will consider your missed appointment a “NO SHOW.” Upon your third missed appointment, you will be dismissed from our practice.

COPAYMENTS and DECUCTABLES are your responsibility and payment is to be made at the time of service. In order to help you meet those requirements we accept cash, check, Visa, MasterCard and Discover. If COPAYMENTS are not paid at the time of service, we will ass a $20 service fee to your account.

Self pay patients will be expected to pay for services, in full, at the time of your visit unless arrangements have been made with our Billing Office prior to your visit. Any questions or concerns regarding your account or insurance should be directed to our Billing Office.

With your cooperation and help, you should be able to receive all the benefits offered to you and will be able to concentrate on caring for your medical needs.

I have read and understand the office policy stated above and agree to accept responsibility as described.

______________________________ ______________________________
Signature Date