Office of Steven Ugras, M.D.
Hand Surgery

Office Policies

These are our established office policies:

1. If your health insurance requires you to obtain a referral, it is your responsibility to bring the referral with you to your visit, or ensure that our office has received it. If you are told that the referral will be sent to our office, you must call us and verify that it has been received. If you have a referral, please verify that it can still be used. Referrals expire after a period of time and after a specific number of visits. You are responsible for fees if the referral is not in.
2. Your co-pay is due at the time of service. We accept cash, and most credit cards. No $100 bills or checks, please.
3. Self-pay patients must pay up front for their visit. There may be additional fees for procedures or x-rays.
4. You are responsible for making sure that our office is notified of **ANY changes in insurance, address, or phone number**. We cannot properly bill your insurance company without this information. In the event you have given us outdated information, the balance becomes your responsibility.
5. Missing a visit without 24 hour notice will result in a fee of 50 dollars and may also result in being discharged from our practice.
6. Surgeries must be cancelled or rescheduled with 48 hour notice, or you may be discharged from the practice and assessed a fee of 150 dollars. Cancelling surgery twice, even with appropriate notice may result in discharge from the practice.
7. Any testing ordered by your physician will be reviewed during a follow-up office visit.
8. Patients are responsible, to pay promptly, and in full any amounts due to the provider, including co-payments, deductibles, returned check fees, and amounts due for non-covered services (such as appeals) that are not payable by my insurance, worker's compensation, lawyer, etc. Patients that do not pay their balances will incur additional fees to cover the costs of collections agencies, lawyers, etc.
9. Any payments written by check that are returned from the bank will be charged a $35 fee additional to the funds previously owed.

I have read, understand, and accept the policies.

Patient Signature: _____ Date:_____

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