San Dimas Family Practice
Kavitha S. Kotrappa, M.D.

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(909) 599-9921

Office Policy Form

Billing Insurance Companies. We will bill most insurance companies for you as a courtesy, provided we have all the necessary information. It is your responsibility to verify with your insurance carrier as to whether you are covered for the medical services provided to you. You must provide us with a correct card. If you do not have a card, we will accept an enrollment form or faxed verification from your insurance carrier.In the event that you cannot provide us with proper verification, you are required to leave us a check. We will hold this check for 3 working days, in which time you must provide us with the necessary information. If you do not, your check will be processed.

Co-payments and deductibles are due when services are rendered. We do not bill for co-payments. Private insurance patients are responsible for all charges not paid by their insurance company within 45 days after date of service. Payment arrangements can be made on an individual basis at our discretion. We reserve the right to withdraw the extension of credit.

Financial responsibility. In the event that you are not eligible for service coverage with this provider or are not eligible at the time services are rendered, you will be held financially responsible.

Failed Appointment. If you are unable to keep a scheduled appointment, you are required to give 24 hour advance notice. In the event that you fail to provide 24 hour advance notice to cancel or reschedule an appointment, or failure to show for an appointment, you will be charged a $25.00 fee.

Late Appointment. **We strive to stay on schedule and make every effort to see patients as near to their appointment time as possible. To that end, if you are late** 15 minutes **or more for your appointment we may reschedule your appointment for another date and time.**

I declare under penalty of perjury under the laws of the State of California that I have read the foregoing, that I understand it, and that by executing this document on the______day of_____________, ___ in the City of San Dimas, California, I accept and agree to its contents.

____ ____________________

Signature of Patient or Guardian *Date:*