

Robert P. Kropac, M.D.
311 Courthouse Road
Princeton, WV 24740
304-487-2297

Patient Name: _____

DOB: _____

Thank you for choosing Robert P. Kropac M.D. for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan including Workers Compensation.
- Copays, coinsurance and deductibles are due at the time of service.
- All amounts non-covered or payable by your insurance including Workers Compensation are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include: charge for returned checks - \$35.00

By my signature below, I understand that I am financially responsible for charges not covered by my insurance including Workers Compensation.

Patient Name _____

Patient/Guardian Signature _____

Date _____