



DR. ELENI SOLOS-KOUNTOURIS, P.C.
ELENI SOLOS-KOUNTOURIS, M.D., F.A.C.O.G.

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“Providing high quality healthcare for all stages in a woman’s life”

FINANCIAL POLICY

The goal of our office is to provide you with the best possible care and service. We would like to make your visit here as good of an experience as possible. In order for us to accomplish this, we are offering the following information:

All of our payments are due at time of service. We accept **VISA, MasterCard, cash and check** in order to assist you.

We have made prior arrangements with most insurance. We will bill the insurances that we have a prior arrangement with as a courtesy to you. We will collect the co-pay at the time of service. For any deliveries, surgeries, or in office-procedures we will again bill your insurance company. For any balance, we will expect to receive it from you upon receiving a statement.

If you need to undergo a service that is not covered by your insurance, you will be responsible for the complete charge prior to the service being rendered.

If you have coverage with an Insurance plan that we do not participate with, you will be responsible for the full payment. We will then give you a receipt that you can submit to your insurance.

It is the patient’s responsibility to request all prescription refills during your scheduled appointment. Any prescriptions lost or not requested at the time of visit will be subject to a \$15.00 fee.

For all services rendered to minors, the parent or other legal guardian will be responsible. Any maternity financial responsibility will be due in full by no later than 20 weeks gestation.

For single page forms that our office has to fill out, there will be a \$35.00 fee. Any extensive forms such as disability forms and FMLA forms will be charged additionally. (Not to exceed \$150.00).

In order to provide the best possible service and availability to all of our patients, we request that all cancellations be made 24 hours in advance. You will be charged an office visit fee of \$50.00 any appointment not cancelled one (1) day prior to the scheduled visit.

We hope that you find the above helpful to you. For any questions please ask our front office staff.

Thank you.

Signature of patient or responsible party

Date

Please print name