Diversity
HEALTH CENTER OF TAMPA BAY
David W. Lyter, MD, MPH

Financial policy

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please understand that payment for your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions.

1. We will verify with you your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards.
2. We require to see and maintain a copy of your current driver's license or other picture identification issued from DMV for identity verification.
3. If you do not have insurance, full payment for the services will be due at the time of service, except in the case of emergency.
4. We accept cash, VISA, MasterCard, Discover, and American Express. We do not accept checks.
5. There may be a $25 fee for any appointment for which you are a "no show" or cancel less than 24 hrs. in advance.
6. If your insurance company requires you to assign Dr. Lyter as your primary care provider, it is your responsibility to obtain this designation prior to your appointment. If this has not been confirmed, your appointment will be rescheduled, or you will be required to make full payment at the time of the visit.
7. The parents or legal guardian accompanying a minor to a visit are responsible for full payment.
8. All laboratory or imaging studies ordered will be billed directly by the vendor to your insurance company. You are responsible for any uncovered expenses.
9. We will submit claims to your insurance carrier(s) for the services we provide to you. Insurance plans vary considerably. We cannot predict or guarantee what part of our services will or will not be covered by your plan. The patient is responsible for knowing the details/rules of their health plan(s).

I hereby authorize this provider to release to my health insurance company any medical information required to permit payment directly to them for any services rendered. I recognize and accept financial responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, co-insurance, deductible, and non-covered services.

I have read, understood and agree to the Financial Policy above.

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Signature of patient or responsible party Date

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Print name of patient or responsible party Date of Birth