Cloutier Family Practice, LLC
Josee D. Cloutier, MD
10 Liberty Way Suite 10B
Niantic, CT 06357
860-691-8084

Southeastern CT Primary Care, LLC
Rosalinda Gaona, M.D.
10 Liberty Way Suite 10B
Niantic, CT 06357
860-691-8084

Financial Policy

Payments of all copays, deductibles and or coinsurance are due at the time of service. If you do not carry insurance payment in full is due at the time of service. These terms are part of your health care contract and we are required to collect these fees. We will bill your health insurance company. The patient is ultimately responsible for the balance, which may include non-covered charges. We will need to confirm your current insurance at each visit. Please make sure we have accurate insurance cards on file both primary and if applicable secondary. If an account is not paid after three billing cycles it may be placed in collections. Any additional fees incurred due to this will be added to the outstanding balance. Please contact the billing office on your statement with any questions.

APPOINTMENT CANCELLATION OR MISSED

You will be charged a $25 fee if your appointment is not cancelled with 24 hour notice and for no show of an appointment

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over directly to Rosalinda Gaona, M.D./Southeastern CT Primary Care, LLC and Josee Cloutier, M.D./Cloutier Family Practice, LLC sufficient monies and or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent(s) in said practice. I authorize the provider to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to the provider. I authorize the provider to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians and providers, and any other third party payers.

I have read and understand the practices financial policy and agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient or guarantor:____

Printed name of patient or guarantor:____

Date:___________________________