Financial and Payment Policy

The following information is provided to all patients on their initial visit to avoid any misunderstanding or disagreements concerning payment of professional services. Self-Pay patients are required to pay for their office visit and services rendered by our office at the time of their appointment.

Payments: Prompt payment allows us to control cost. Outstanding accounts cost both time and money; therefore, all patients will be required to establish financial arrangements for payment on their accounts. By law all accounts are due and payable within 30 days of services rendered, a statement has been mailed and received. As a courtesy, our practice will establish a reasonable payment plan to help accommodate your needs.

If you have health insurance coverage, for covered services provided, it is an agreement between you and your insurer. It is your responsibility to ensure that they remit payment and that you remit payment for services not covered, as in a co-payment deductible or coinsurance. Co-Payments are due at the time of service. If your insurer requires a different co-payment for such, please be aware this office is considered a specialist provider.

Consent to Appeal: In the event that your insurance denies payment for any service rendered during your care, you authorize our office to file a grievance for payment on your behalf: you understand you have the right to rescind your consent to appeal at any time during the appeal process. If you consent our office to file a grievance on your behalf, you understand you will not be able to file your own grievance concerning the same services, nor will any representative you appoint, unless this consent is rescinded in writing. This consent shall automatically be rescinded and you may fil your own grievance is your health care provider does not file a grievance or stops grieving your case.

Statement to Permit Payment of Medicare Benefits to Provider: You authorize any holder of medical information about you to release to the centers for Medicare services and its agents any information needed to determine these benefits or the benefits payable for related services.

You Request that payment of authorized Medicare benefits be on your behalf to CTFA for any services furnished to you by our office.

Statement to Permit Payment of Medicaid Benefits to Provider: You certify that the information given to you in applying for payment under Title XIX of the Social Security Act is correct. You authorize any holder of medical or other information about you to release to the Department of Public Welfare (D.P.W.) or its intermediaries or carriers any information needed for this or related Medicaid claim. You request payment of authorized benefits be made on your behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such Physician or organization to submit a claim to D.P.W. for payment.

Referrals: Some insurance carriers require the patient to obtain a referral for their primary care physician before seeking treatment from a specialist. It is important for you to insure if you are required to have on to have this completed prior to your appointment. We submit all claims to your insurance carrier and we accept their "allowance" as full payment excluding Coinsurance and Co-Payments which are your responsibility. If you do not obtain a referral when one is required your insurance company will not pay for your visit and you may be responsible for the cost incurred during your visit.

Acknowledgment of Responsibility for a payment of a bill: Each month you will receive a monthly statement; all services unpaid are due and payable within 30 days. If your payment is late or you have previously made financial arrangements then we will mail a reminder notice if there is a problem with your account. If you are experiencing unforeseen problems and need special considerations regarding your payment, please call our office we will be happy to work out an arrangement with you. All patients that are more than 61 days behind and have not made special arrangements with payments will force us to limit future credit until all balances are paid in full. Please notify us immediately if you see an error on your statements. All returned Checks for Non-sufficient funds will be subject to a $30.00 fee that will be added to your balance.

Collections: Should your account be referred to an attorney for collections, you agree to pay not less than 35% for attorney fees and collections expenses. Late payments over 61 days are subject to a 5% service fee. Our staff has been instructed to clarify any misunderstand you may have concerning your balance.

FMLA, Disability, and Insurance Form Fees: $15 per form please allow up to 2 weeks for completion.

Medical Record Request: are billed as $20 for the first 5 pages and .50 per page thereafter.

I the undersigned agree to these terms

Name_____ Printed Name_____ Date_____