



FINANCIAL ARRANGEMENT AND INSURANCE

It is our goal to help you to understand the policies and requirement of our office. It is important to note that our relationship is with you. YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, not between us and your insurance company.

We participate with many insurance companies, and these companies offer different lines of coverage- PPO's, HMOs and Traditional coverage. We also do participate with MEDICARE, but not participate with any form of MEDICAID! Please be aware of your own policy benefits. Every insurance policy is different. It is YOUR responsibility to obtain insurance referrals from your Primary Care if they are required by your insurance policy. The referral needs to be in our office prior to your appointment. Please be aware of the expiration of your referral, as you may need to obtain a new one from your Primary Care for your next visit.

We are very happy to submit a claim to your insurance company for your visit to our office. However, many insurance plans have higher out-of-pocket expenses. These could include deductibles and copayments that are the patients responsibility. If the insurance company does not cover the services for any reason, it is your responsibility to pay us promptly for any service rendered. If a payment to us becomes 30 days past due, it is considered delinquent. If an overpayment is made on your account, we do not issue refund checks for any balance less than \$30. We will apply the credit to your next balance due.

LABORATORY SERVICES

We may sometimes use an OUTSIDE LABORATORY to perform certain tests. Lab tests are not included in the physician's fees. You are responsible for all costs incurred by the lab which are not covered by your insurance, and you will be billed separately by the lab themselves. Please contact the laboratory directly for any questions you may have.

I understand that it is my responsibility to be aware of my insurance benefits. If, for any reason, any portion of my bill is not paid by my insurance company, I further agree to pay any **outstanding amounts not covered by my insurance promptly**. In the event of non-payment, I will bear the cost of collection proceedings should this be required.

If you have any questions about the above information please do not hesitate to ask.

PLEASE LIST PERSON RESPONSIBLE FOR COPAYS & DEDUCTIBLE _____

SIGNED _____ DATE _____