

(Practice Name)

OFFICE FINANCIAL POLICY

Dear Patient:

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:
 - a. The annual deductibles
 - b. Co-payments
 - c. Charges for non-covered or cosmetic services

In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

2. We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:
 - a. The annual deductibles
 - b. Co-payments
 - c. Charges for non-covered or cosmetic services*

* You will be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within ____ days after we file a claim, you will be sent a bill and will be responsible for the balance.

3. For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:
 - a. We will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within ____ days of filing, you will be billed for the entire amount. Payment is due ____ days after receipt of the statement.
 - b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within ____ days of filing, you will be billed for the entire amount. Payment is due ____ days after receipt of the statement.
 - c. If you only have primary insurance (e.g., no secondary/supplemental coverage), you will be asked to prepay 35% of the entire bill. Any amount not paid by your insurance company will be billed to you. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. The entire balance remaining after your primary carrier has paid will be billed to you and is due and payable ____ days after receipt of the statement.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient Signature: _____ Date: ____/____/____