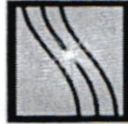

Office Policies

We are dedicated to providing the best possible care for you. Therefore, we would like you to completely understand our financial policies:

- Payment is due at the time of services are rendered unless prior arrangements have been made in advance. We accept Check, Cash, Visa, MasterCard, American Express and Discover Card.
- There is a **$50.00 fee** for any returned checks.
- If all attempts on our behalf to collect a debt have not been satisfied, we will forward the account to a collection agency.
- We have made prior arrangements with insurance companies and other health plans to accept assignment of benefits. We will bill them and you are required to pay your portion at the time of your visit.
- **Cancellation policy**: To ensure your quality of care as well as the quality of care of all other scheduled patients, we require a **48 hour notification** in the event that your appointment must be cancelled or rescheduled. Any cancellation that occurs within 48 hours will result in a **$50 fee**.

Keep in mind your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your claim if you assign the benefits to the doctor- in other words; you agree to have your insurance company to pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to bill you for payment. If we later receive a check from the insurer, we will refund any overpayment to you.

Insurance Carrier Name: ____

1. **Insufficient Proof of Coverage**:

    - I did not bring the necessary referral and/or authorization needed. I understand that I am financially responsible for all charges incurred until such a time as I provide the necessary referral and /or authorization which covers previously rendered services and/or future services.

    - I understand that my predetermination and/or verification of benefits have not been received back from my insurance carrier. I know and understand I may not have the benefits and will be responsible for all charges.

2. **Self-Pay**:

    - I am not covered under a health insurance plan and understand that all fees rendered are my responsibility.
    - I have insurance coverage with the above named plan, however, I choose to waive the coverage and pay for services rendered.

3. **Self-Pay – Coverage but Desire to Begin Treatment:**

- I wish to start testing and/or treatment without first obtaining the necessary referral and /or authorization. I understand I am responsible for all charges incurred from this point forward or until authorization is obtained.

4. **Non-Participating Agreement:**

- I understand that I have an insurance plan that may require me to go to physicians or a laboratory within a specified network of providers. I am aware that my physician is not a participating provider within my insurance plan. I have chosen not to use my insurance benefits in seeking treatment with this not-participating physician. I agree to be financially responsible for all services determined by my doctor and me to be appropriate. I understand and agree that no reimbursement will be obtained from my insurance company.

- I understand that I have an insurance that may require me to go to a physician or laboratory within my insurance carrier's network of providers. I am aware that my physician is not a participating provider with my insurance plan. I agree to be financially responsible for all services determined by my doctor and me to be appropriate. I understand that I may not receive reimbursement from my insurance carrier or that my benefits may be reduced.

5. **Verification/Authorization of Coverage Obtained but Claims Denied**:

- I understand that any predetermination and/or benefits verification is not a guarantee of payment. Claims must be submitted and reviewed by the insurance carrier prior to any payment. Any Claims denied by my insurance company may become my responsibility for payment.

6. **Receipt of Insurance Payments:**

- I understand that if my insurance company pays me directly, I am obligated to turn over all payments to the practice in a timely manner; otherwise the practice may not be able to submit to any other additional carriers on my behalf.

7. **Non-Covered Services or Exclusions:**

- I understand that some of the services that I am receiving could be considered "non-covered" or apply to a contract exclusion. I agree to be financially responsible for all non-covered services and understand that payment is required prior to time of service. Example: Gradient Compression Stockings is a non-covered service.

8. **Exceed Plan Limits:**

- It is possible that I have exceeded my insurance plan limits. I agree to be financially responsible for any services that exceed my plan limits.

9. **Ineligible for Insurance Benefits on Date of Service:**

- o I am aware that my insurance coverage is not eligible on this date of service and I choose to pay for the services rendered from this point forward or until I am eligible.

Consent to Treatment:
As part of the course of the diagnosis and treatment of my medical condition, I voluntarily consent to the provision of all diagnostic tests, physical examinations, medical procedures, medications and other items and services that Dr. Alexander Goldman and/or Dr. Saluja Varghese (My Doctor) deem appropriate to diagnosis and treat conditions that I discuss with my doctor or care providers. I acknowledge that no guarantees have been made to me about the outcome of any services provided by my doctor or care providers.

In accordance with my understanding of the above, I hereby agree to payment at time of service or prior to the start of my global cycle if applicable.

Patient Name (Print):____

Patient Signature:____

Practice Employee:____