Northeast Medical,P.C.
□ 2865 Genesee Street | Cheektowaga, NY 14225 Phone: 716-262-0616 | Fax: 716-262-0631
□ 3488 Sheridan Dr | Amherst, NY| 14226 Phone: 716-832-6207 | Fax: 716-832-3282
www.northeastmedicalpc.com

Financial Policy: Please sign below to indicate you have read and understand the following:

Patient Name:_____ DOB:_____

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

1. Responsibility for payment of your account always remains with you; and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if your claim is related to NY WORKERS COMP, AUTO RELATED, OR THE RESPONSIBILITY OF A THIRD-PARTY PAYOR.

2. Please understand that it is your responsibility to make sure your PCP is up to date with your insurance.

3. Copays and other estimated out of pocket amount due are to be collected at the time of service. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

4. You will receive a monthly statement showing itemized charges and the total amount due on your account. Payment in full is required within 30 days of the statement date, unless arrangements are made with our billing office.

5. If you need to set up a payment plan, our Main billing phone number is (716)832-6207.

6. Northeast Medical, P.C. and/or contracted collection co. may need to contact you for additional information or to collect any amounts you may owe. You give your express agreement and consent to allow Northeast Medical, P.C. and/or contracted collection co. to call you at any telephone number provided or obtained, without limitation of wireless. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

7. A $35.00 fee will be charged to your account if you do not cancel your appointment 24 hours in advance. After three no show appointments, you will be subject to discharge from Northeast Medical, P.C.

8. There is a $35.00 fee for all returned checks and for stop payments.

9. No credit will be extended to patients having a past due account, or to patients who have been referred to a collection agency. If your account has been referred to a collection agency two times, you will be discharged from Northeast Medical, P.C.

10. If you arrive more than ten minutes late to an appointment, you may be asked to reschedule.

11. Northeast Medical, P.C. requires 2 business days to respond to all medication refill requests. Medications will not be refilled after office hours. Please contact your pharmacy to initiate refill requests.

12. CASH PAY POLICY
    Patients without medical insurance are required to pay $130.00 at the time of service to see a primary care provider. Please note that your balance may be more than the above stated amounts and will be determined based on actual services rendered during your office visit.

13. PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through NORTHEAST MEDICAL, P.C. providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a NORTHEAST MEDICAL, P.C. billing statement whether it is an interim or final bill. If I fail to make full payment or fail to comply with other payment arrangements made with NORTHEAST MEDICAL, P.C.'s approval, I understand that appropriate collection measures may be initiated.

14. RESTRICTED SERVICE: I understand that all account balances must be in good standing prior to receiving additional services and will contact NORTHEAST MEDICAL, P.C.'s staff if I am unable to pay your balance. Past Due Accounts of 60 days or longer may be turned over to a third-party for collection, along with collection costs, attorneys' fees and court fees. I also understand I may be discharged from the practice.

_____ _____

Patient/patient representative signature Date

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

___Spouse Guarantor
___Parent
___Healthcare Power of Attorney
___Legal Guardian
___Other (please specify) _____