

Greenfield, M.D. and Associates, P.A. Financial Policy

Thank you for choosing our practice for your healthcare. We are committed to providing you with excellent medical care. The purpose of this form is to explain our business financial policies and patient responsibilities.

PROVIDE ACCURATE INFORMATION

Please provide accurate and complete information regarding your health insurance and health history. If any information changes such as name, address, phone number, email, or insurance coverage, please inform the practice immediately.

UNDERSTANDING YOUR INSURANCE COVERAGE AND BENEFITS

Your healthcare contract is between you and your insurance carrier. Patients are responsible for understanding their benefits and coverage, as there may be limitations and exclusions. Our providers participate with Medicare insurance. Participation, or accepting assignment, means we have a contractual agreement with Medicare to accept an approved amount as full payment for covered services. On your behalf, we will submit your medical claims and await payment, less any copayments or deductibles that are the patient's responsibility. **Copayments or deductibles, if applicable, are due at time of service as it is a requirement placed on you by your insurance company.**

Some patients have a managed care plan or HMO and are required to use certain laboratories, testing facilities, doctors, specialists, and hospitals. This is not always apparent to patients who may not be familiar with their insurance policy. If you utilize a service that is not approved by your insurance company, you may be using "out-of-network" benefits that may result in you paying a greater out-of-pocket expense for these services or be fully responsible for payment of fees due to Greenfield, M.D. and Associates, P.A.

Commercial Insurance – We do not participate with any insurance companies other than Medicare. As a courtesy, we will verify your insurance and deductible balance, whether the insurance company will pay us for your service, and estimate their payment. Any balance remaining on your account is your responsibility. If needed, we will assist you with your insurance submissions and we are always available to answer your questions.

MISCELLANEOUS SERVICES AND RELATED FEES

- 1) Missed appointments - There is a \$50.00 fee for missed appointments or any appointments changed with less than 24 hours notice. We recognize there may be circumstances that may not permit such notice and those shall be considered on an individual basis. This policy helps make appointments available to other patients.
- 2) Completion of medical forms - \$100.00-\$150.00.
- 3) Medical records requests - \$0.73 per page for first 30 pages, \$0.20 per page for remaining pages.
- 4) Returned checks are subject to a \$35.00 fee.

I accept full responsibility and agree to pay Greenfield, M.D. and Associates, P.A. for all charges not fully covered by my insurance. I understand that payment is due within 30 days of the statement date. I understand that Greenfield, M.D. and Associates, reserve the right to seek payment of delinquent accounts through a collection agency. Any fees or court costs incurred during the collection process will be my responsibility.

Patient Signature

Date