THE OFFICE OF DAVID HERSON MD

FINANCIAL POLICY

WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OF SOME OF OUR FINANCIAL POLICIES.

INFORMATION REGARDING YOUR INSURANCE COVERAGE

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc.). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office (internal and/or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

UNINSURED PATIENTS

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service.

NON-PARTICIPATING PROVIDER OR NON COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes. (Please Note: In certain rare circumstances - and in our sole discretion- we may directly bill your insurance carrier as an out-of-network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights to our office and forward us any checks you receive relative to the services we have provided to you.)

PARTICIPATING PROVIDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, deductibles and fees for non-covered services), which are due at the time of service.

TYPES OF PAYMENT; DISHONORED CHECKS

Our office accepts cash, personal checks, Master Card, Visa, and debit cards. If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of twenty dollars, which shall be due and owing immediately.

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

MISSED APPOINTMENTS

It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled appointment. If speaking to you is not possible for any reason, we attempt to leave a reminder message with a family member or on an answering machine/voicemail.

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). We charge a photocopying fee of 25 cents per page.

MISCELLANEOUS FEES

Certain services (e.g., family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. Prior to requesting any such services, you should request a copy of our miscellaneous services fee schedule.

By signing below, patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

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Signature of Patient or Responsible Party

_____

Print Name of Patient and Responsible Party (if any)

_____

Date