



**FINANCIAL POLICY**

**WE BILL YOUR INSURANCE AS A COURTESY. PLEASE REMEMBER THAT YOU ARE FINANCIALLY RESPONSIBLE FOR ALL SERVICES. WHILE WE MAKE EVERY EFFORT TO VERIFY YOUR INSURANCE COVERAGE, IT IS THE RESPONSIBILITY OF OUR PATIENTS TO KNOW IN ADVANCE ABOUT THEIR INSURANCE PLANS. WE UNDERSTAND THERE IS A LOT OF CONFUSION WITH ALL OF THE CHANGES IN HEALTH CARE AND INSURANCE'S; HOWEVER, ANY DENIED SERVICES, EXPIRED PLANS OR OTHER CHARGES THAT RESULT IN NON-COVERAGE BY THE STATED PLAN WILL BECOME THE RESPONSIBILITY OF THE PATIENT. DELINQUENT ACCOUNTS WILL BE SUBJECT TO MONTHLY SERVICE CHARGES.**

**RETURNED CHECK POLICY:** All returned checks due to insufficient funds will be subject to a 10% service charge or \$25 (whichever is greater) per check. All accounts may be turned over to collections at our discretion.

**MEDICARE ONLY:** You will be responsible for your Medicare yearly deductible (\$100) plus the co-insurance (20%). If your deductible has been met, you will be responsible for your 20% of the Medicare allowed charges. We will bill Medicare, and upon receipt of payment or notification from Medicare you will receive a statement showing the balance due. Occasionally, though rarely, Medicare will declare a service as non-covered. In this case the patient will be responsible for these charges.. **IN ORDER TO HELP REDUCE OUR RISING COSTS, MEDICARE CO-INSURANCE PAYMENTS WILL BE DUE AT THE TIME OF SERVICE (BASED ON THE MEDICARE APPROVED FEE SCHEDULE). WE APOLOGIZE FOR ANY INCONVENIENCE THIS MAY CAUSE.**

**MEDICARE WITH SECONDARY INSURANCE:** We will bill both of these carriers as necessary. You will be responsible for any deductibles or other charges not covered by these insurance carriers. You may receive a statement at the beginning of each month. This statement will tell you of all account activity and the status of your account.

**PRIVATE INSURANCE ONLY:** We will bill this carrier. If it is through an HMO or Managed Care System we require a referral from a primary care physician. The patient is responsible for any co-pay or patient portion designated by the insurance carrier. If you have a deductible, you are responsible for these charges until the deductible is met. You will be required to pay these charges at the time of service. A monthly statement may be sent out at the beginning of each month showing the balance due.

**PRIVATE PAY:** Non-insured patients must pay the fee at the time of service.

**MEDI-CAL ONLY:** If you are covered under Medi-Cal or a Geographic Managed Medi-Cal Plan (Blue Cross, Molina) you must bring your eligibility card with you every visit. You must have a written referral from a primary care physician, insurance company, emergency room or diabetes clinic. **Share of cost recipients will be required to pay at the time of service.**

**MISSED APPOINTMENTS:** All missed appointments will be subject to a \$45.00 missed appointment fee. The ONLY exception is that you have called the office prior to your appointment to notify us. You will receive a statement within 48 hours of your missed appointment. (Revised 01/10/07)

**INITIALS** \_\_\_\_\_



**ACKNOWLEDGEMENT OF RECEIPT OF**  
**NOTICE OF PRIVACY PRACTICES**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the notice.**

\_\_\_\_\_  
**Patient Name (print please)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient or Authorized Representative (if applicable)**

\_\_\_\_\_  
**Signature**