

GRUENWALD & COMANDATORE, MDs
PATIENT FINANCIAL POLICY

Insurance: Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions.

- IF WE PARTICIPATE WITH YOUR INSURANCE CARRIER, all services provided in our office (unless otherwise indicated) will be submitted to your insurance.
- IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER, IF YOU DO NOT HAVE HEALTH INSURANCE, IF WE ARE NOT YOUR PRIMARY CARE PROVIDER (PCP) AND YOU STILL CHOOSE TO BE SEEN, OR IF WE CANNOT VERIFY INSURANCE COVERAGE, payment in full is expected from you at the time of your visit.

Proof of Insurance: All patients must complete our patient registration form before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.

Out-of-Pocket Expenses: Certain office procedures or services may not be covered or may be applied to your deductible or co-insurance. Copays and past due balances are due and payable at the time of service. Copays not paid at the time of service are subject to a five dollar (\$5.00) surcharge. Patient balances will be billed within thirty days after receipt of the insurance company's payment. Although we do not mail statements with balances less than five dollars (\$5.00), the patient will still be responsible for payment as it will reflect on their account.

Non-Insurance Services & Fees: Patients will be responsible for services and fees not related to health insurance claims such as, but not limited to, Forms, Letters, Record Release, and No-Show fees.

Divorce/Child Custody Cases: The guardian who accompanies the child is responsible for payments of copays, coinsurance and nonparticipating insurance balances at the time of service. It is the parent's responsibility to first make the appropriate payment to us when services are rendered. We are not party to divorce judgements.

Delinquent Accounts: You will be billed an additional Collection Fee of fifty dollars (\$50.00) or 20% of the balance owed, whichever amount is greater, if your account is referred to an outside agency or attorney for collection.

Extended Payment Arrangements: We offer "Easy Pay," a credit card payment service. All arrangements must be addressed to a Patient Account Representative.

Return Check (NSF) Fee: A fee of thirty-five dollars (\$35.00) will be charged for all returned checks.

Credits: If an account has a credit, the patient will be notified. The patient will have the option to have a refund issued, or keep the credit on the account to be applied toward the next visit.

I, the undersigned, give my authorization to treat and assign directly to Gruenwald & Comandatore, MDs all medical benefits, if any, otherwise payable to me, for services rendered. I understand that I am ultimately financially responsible for all charges, whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health insurance information for purposes of treating me/my children, obtaining payment for services rendered to me/my children, and conducting healthcare operations.

Patient Signature or Parent/Guardian Signature

Date

Patient's Printed Name

Revised: 3/23/2017