M.P. VEERA MD PA 864-224-8689
FINANCIAL POLICY

WE THANK YOU FOR CHOOSING US FOR YOUR MEDICAL CARE. WE HOPE THAT YOU WILL RECOGNIZE THAT OUR FINANCIAL POLICY IS A NECESSARY PART OF ASSURING THE RESOURCES REQUIRED TO MAINTAIN THIS PRACTICE FOR OUR PATIENTS & COMMUNITY. **WE ACCEPT CASH, CHECKS, DEBIT CARDS, VISA, DISCOVER, AND MASTERCARD.WE DISCUSS CHARGES PERTAINING ONLY TO OUR OFFICE IN THIS DOCUMENT.**

MEDICARE/MEDICAID: WE ACCEPT ASSIGNMENT. FEDERAL LAW REQUIRES US TO COLLECT AT THE TIME OF SERVICE 20%OF MEDICARE ALLOWED CHARGES EITHER FROM YOU OR YOUR SECONDARY/SUPPLEMENTAL INSURANCE COMPANY. YOU MAY BE ASKED TO SIGN A WAIVER FOR TEST/PROCEDURE/OFFICE VISIT THAT MEDICARE DOES NOT COVER. YOU HAVE THE RIGHT TO REFUSE THE TEST/PROCEDURE/OFFICE VISIT. YOU WILL BE ASKED TO SIGN A WAIVER STATING THAT YOU HAVE REFUSED THEM. **PATIENT'S CERTIFICATION:** IF YOU ARE A MEDICARE/MEDICAID BENEFICIARY YOU AGREE THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO M.P. VEERA MD PA FOR ANY SERVICES FURNISHED TO YOU. ADDITIONALLY YOU AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT YOU TO BE RELEASED TO HEALTHCARE FINANCING AND ADMINISTRATION AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES.

CONTRACTED HMO'S, MANAGED CARE, PPO'S, EPO'S, POS, AND OTHERS: YOUR HEALTH INSURACE IS AN AGREEMENT BETWEEN YOU, YOUR EMPLOYER, AND YOUR INSURANCE COMPANY. AS NOTED IN OUR WELCOME LETTER, AT THE TIME OF SERVICE, YOU WILL BE RESPONSIBLE FOR ALL COPAYS, COINSURANCE, DEDUCTIBLES AND SERVICES NOT COVERED BY YOUR PLAN. FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED REST WITH THE PATIENT, REGARDLESS OF ANY INSURANCE COVERAGE. ALTHOUGH WE WILL DO EVERYTHING POSSIBLE TO OBTAIN REIMBURSEMENT, WE CANNOT GUARANTEE PAYMENT OF YOUR CLAIM. INSURANCE FOLLOW UP IS PATIENT RESPONSIBILITY. WHEN THE CLAIM BECOMES PATIENT RESPONSIBILITY, THE CLAIM MUST BE PAID WITHIN 30 DAYS. IT IS THE PATIENT'S RESPONSIBILITY FOR OBTAINING AND MAINTAINING VALID REFERRALS FOR ANY AND ALL COVERED SERVICES. IF THE PATIENT CHOOSES TO UNDERGO ANY SERVICE WITHOUT A VALID REFERRAL, THE PATIENT IS FINANCIALLY RESPONSIBLE FOR PAYMENT IN FULL. YOU HEREBY AUTHORIZE PAYMENT TO BE MADE FROM YOUR INSURANCE COMPANY TO OUR OFFICE. IN THE EVENT ANY OVERPAYMENT IS MADE FOR MORE, THE OVERPAYMENT WILL BE SENT TO THE APPROPRIATE PAYER.

NON-CONTRACTED INSURANCE: PATIENTS WHO HAVE SUCH POLICIES WILL BE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICES. AS A COURTESY, WE WILL FILE YOUR CLAIM WITH YOUR INSURANCE COMPANY.

SELF-PAY, HIGH DEDUCTIBLE AND YEARLY MAXIMUM BENEFIT PLANS: PAYMENT IS REQUIRED PRIOR TO SEEING THE DOCTOR. FOR PAYMENT ARRANGEMENTS, IT IS IMPORTANT THAT YOU ASK OUR BILLING PERSONNEL ABOUT THE COST OF CARE THAT YOUR DOCTOR IS RECOMMENDING PRIOR TO SERVICES BEING PERFORMED.

CHANGE OF INSURANCE: IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH ANY INSURANCE CHANGES. ANY CLAIMS DENIED AS LATE OR UNTIMELY BILLING WILL BECOME YOUR RESPONSIBILITY IN FULL.

OCCASSIONALLY, WE ORDER **LABS** WHICH ARE DONE AT OTHER FACILITIES THAT MAY BE **OUT-OF-NETWORK** WITH YOUR INSURANCE. PLEASE DISCUSS THIS WITH THE FACILITY AND INSURANCE COMPANY BEFORE YOUR LABS ARE DRAWN

COLLECTIONS AND NSF CHECKS: IF UNUSUAL CIRCUMSTANCES SHOULD MAKE IT IMPOSSIBLE FOR YOU TO MEET OUR CREDIT TERMS, PLEASE CALL OUR OFFICE/BILLING. THIS WILL ENABLE YOU TO KEEP YOUR ACCOUNT IN GOOD STANDING. EXCEPT WHEN HARDSHIP OR PREVIOUS CREDIT ARRANGEMENT WARRANT, ACCOUNTS THAT ARE 90 DAYS PAST DUE WILL BE TURNED OVER TO A COLLECTION AGENCY WHO WILL CONTACT YOU VIA YOUR HOME AND/OR CELL PHONE NUMBER. THEY MAY ALSO BE SENT TO THE MAGISTRATE'S COURT. IN THE EVENT LITIGATION IS NECESSARY YOU WILL BE LIABLE FOR COURT AND ATTORNEY FEES. **A $15.00 FEE WILL BE CHARGED FOR ANY NSF CHECKS.** THE **SAFEKEEPING OF ANY VALUABLES** AND PERSONAL PROPERTY BROUGHT INTO OUR OFFICE AND PREMISES IS YOUR RESPONSIBILITY.

YOUR SIGNATURE AFFIRMS THAT YOU HAVE READ, UNDERSTOOD AND AGREE TO ADHERE TO OUR FINANCIAL POLICY.

PATIENT OR AUTHORIZED REPRESENTATIVE____ DATE____________