FINANCIAL POLICY FOR DR GRABOWSKI, PC

Thank you for choosing our office for your medical care. We are committed to serving you with the highest skill and quality. The podiatry care provided by Dr. Grabowski PC. are services you have elected to receive and they may imply a financial responsibility on your part.

COPAYS. Co-pays are due at the time of service.

SELF PAY. Payment in full is due at the time of service if you do not have health insurance.

MEDICARE. We are a participating Medicare provider. Medicare as well as your secondary insurance will be billed for you. You are responsible for any co-payment or deductible amounts as stated by Medicare and your secondary insurance company

SECONDARY INSURANCE. Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. As a courtesy, we will bill your secondary insurance once. However, if your secondary insurance is unpaid the bill will be transferred to patient responsibility.

REFERRALS/AUTHORIZATIONS. We are required to follow the guidelines of your managed care plan. Prior to visiting a specialist, you must have a referral authorized from your primary care physician. Unless your referral is presented at the time of this visit, you are financially responsible for the services received. You will be given the option to reschedule your appointment without a cancellation fee. Otherwise without an authorized referral, payment is due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of that visit.

PATIENT BILLING. You will be sent three notices of your financial responsibility after payment and/or explanation of benefits (EOB) is received from your insurance company. After the third notice your account may be forwarded to collections with Westcoast Adjustors. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard and Discover. An additional $25.00 will be added to your statement if the check is returned for insufficient funds.

In the event that your insurance company should happen to send payment to you, the patient, we will expect that you would forward it to our office to be applied to your balance.

PRIVACY STATEMENT. Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

ASSIGNMENT OF BENEFITS.

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to DR. GRABOWSKI, PC all insurance benefits for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

My signature confirms that I have read the above policy regarding my financial responsibility to Dr. Grabowski, PC. I agree to pay Dr. Grabowski, PC. in full any balance incurred by me or my dependent in the event that there is no health insurance coverage. I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

FINANCIALLY RESPONSIBLE PARTY:

PATIENT: _____ _____ ____/__/_____
Signature Print Date

GUARANTOR: _____ _____ ____/__/_____
Signature Print Date

Guarantor's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other