ENDOCRINE ASSOCIATES FINANCIAL POLICY

Our office submits your medical claims to your insurance company as a courtesy to you, but it is your responsibility to give our office staff the correct insurance information and any necessary special forms. Your insurance policy is a contract between you and your insurance company, and it is ultimately your responsibility to know the status of your account. If your insurance company has not paid your account within 60 days, the balance will be billed to you. It is also your responsibility to inform our office staff of any changes in your insurance information. In the event that you do not notify our office of any new information before your office visit, you will be responsible for those charges in full.

A service charge of 1.5% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

- **Co-payments:** ALL co-payments and co-insurance percentage payments are due at the time services are rendered. Our office accepts cash, checks, debit cards, Mastercard and Visa.
- **Secondary Insurance Plans:** Our office is unable to submit to secondary insurance plans (with the exceptions of Medicare and Tricare). At the time of your visit we will provide you with a summary of the charges. This summary, along with the Explanation of Benefits that you will receive from your primary insurance company, is all you will need to submit to your secondary plan. If we do not provide you with a summary of the charges- be sure to ask for one!
- **Medicare Patients:** Our physicians participate in the Medicare program. For those patients with Medicare as their primary insurance, our office will file claims to your secondary insurance policy as well.
- **Tricare Patients:** Please call ahead to verify that you have a current, valid referral on file with our office. Remember that most referrals are only valid for a certain amount of visits and a limited period of time. Our office will not be able to see you until we have a current referral on file.
- **Medicaid Patients:** All patients must have a current referral on file with our office for every visit. Please call ahead to make sure that you have a valid referral on file. Obtaining all necessary referrals from your insurance is your responsibility. You will not be seen by our doctors until we have a current referral on file.
- **Appointments:** We make every effort to meet our patients' needs in scheduling appointments. All visits with the physicians are by appointment only and we request that patients arrive promptly for their appointments. If you must cancel or change your appointment, please contact us at least 24 business hours in advance so that other patients who need to be seen may be accommodated. If 24 business hours notice is not given a cancellation/reschedule fee of $35.00 for follow up appointments or $75.00 for new patients may be charged.
- **Administration Charges:** Charges may apply to some "non-covered" services. These may include: prescription refills, drug authorizations, completion of certain forms and photocopying of medical records.

AUTHORIZATION

I hereby authorize Harvey A. Rubenstein, M.D., P.C., Frank R.Crantz, M.D., or S. Mark Tanen, M.D., LLC to apply for benefits on my behalf (or my child's) for services rendered. I also hereby authorize payment of the insurance benefits, otherwise payable to me directly, to the doctor.

I authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I agree to be responsible for charges not covered by my health insurance.
I understand that I will be held financially responsible for all costs involved with the collection of monies for this account including all court costs, reasonable attorney fees, and all other expenses incurred with the collection.

I have read and understand the above information. I understand I am responsible for charges incurred from services rendered.

SIGNATURE ____ DATE ____________