



FINANCIAL POLICY :

Thank You, for choosing Dingmans Medical as your healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our billing department will be available to discuss our fees and this policy with you. We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician. (**You will not be able to see the physician without a signed financial policy.**)

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, and check. As a courtesy to you, it is the policy of Dingmans Medical to bill your insurance carrier, although you are ultimately responsible for the entire bill. It is ultimately the patient’s responsibility to know their benefits and which lab they are affiliated with. As the responsible party, please understand: (PLEASE INITIAL THE FOLLOWING)

_____1.) Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and “usual and customary” charge. As your medical provider, we will only supply factual information to facilitate claim processing. Claims can not be adjusted to reflect a diagnosis code based on what your insurance company does or does not cover.

_____2.) All charges are your responsibility. It is your responsibility to provide your insurance company with the information needed to adjudicate your claim, such as updated coordination of benefits and student status. If any payment is made directly to you for services billed by Dingmans Medical, you recognize an obligation to promptly remit payment to Dingmans Medical.

_____3.) I hereby authorize direct payments of medical benefits to Dr. Lisa Pathak for services rendered. I understand that I am financially responsible to Dr. Lisa Pathak for any balance not covered by my insurance company. I certify that the information I have given in applying for payment is correct, and I authorize release of all medical records upon request. A photocopy of these assignments shall be valid as the original.

_____4.) I hereby authorize Dr. Lisa Pathak to release any medical or incidental information for either medical care or in processing applications for financial benefits. I also authorize any doctor to release necessary medical records that are requested by Dr. Lisa Pathak’s office.

_____5.) Fees for services, which include unpaid balances, deductibles, co-payments and co-insurances, are due at the time of service. **If copayments are not given at the time of service, you will be subject to an additional \$5.00 billing fee. Returned checks will result in a \$25.00 fee to cover the fee the bank has charged us.** Nonpayment on 4 or more billing statements will result in the account being sent to Credit and Collections. Credit reporting and legal action may take place after 90 days if the account is neglected. All forms that need to be completed will be subject to a fee of \$10.00 **UNLESS** done at time of visit.

_____6.) Please note that for any reason, if you are unable to make your appointment, we require notification at least 24 hours in advance. Failure to do so, will incur an additional fee of \$25.00, regardless of your required co-payment. If you have (3) three or more “no show” appointments, your case will be reviewed and you will be liable for possible discontinuation of care. If you arrive (20) twenty or more minutes late to your appointment time, you may be asked to reschedule for another day.

_____7.) Anyone under 18 (eighteen) years of age, must be with either one or both parents. If the situation presents with a minor coming in with anyone other than a parent, full documentation is needed proving guardianship, or there must be a signed permission form on file from the parent, allowing the individual/ agency to accompany the minor for medical treatment.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Print Name: _____ Account #: _____

Signature of Responsible Party

Date