

Drew A. Stein, MD

FINANCIAL POLICY

We recognize the need for a definite understanding between you and your physician concerning healthcare and the financial arrangements for the medical care. Our commitment is to provide the very best healthcare to our patients. The responsibility for payment of fees for these services is the direct obligation of the patient. Any financial payment you may receive from private insurance or government agencies is a matter strictly between you and the insurance carrier or government agency. Our physicians are participating Medicare physicians.

It is also your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and/or co-insurance. The same responsibility exists for HMO and PPO insurance.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO, or your employer. While we will try to be helpful, and we may participate in your plan, your benefit plan determines your coverage, requirements for prior authorizations or referral, and establishes the limit on your coverage for medical services.

PAYMENT POLICY:

Co-payments -	Full payment at the time of service
Deductibles -	Full payment at the time of service
Co-insurance -	Full payment at the time of service
Non-covered service -	Full payment at the time of service
Missed Appointments -	The office requires 48 hours notice (not including weekends) to cancel an appointment. Failure will result in a \$25.00 fee.
Administrative Forms -	\$20.00 fee
Medical Record Copies -	\$0.75/page fee
Return Checks -	\$20.00 fee
Cancellation of Surgery -	\$1000.00 fee (<48 hours); \$500.00 (3 to 7 days)

We realize that temporary financial problems may affect timely payments on your account. If such problems do arise, we encourage you to contact our office promptly for assistance to manage your account. If you have any further questions about this information please do not hesitate to ask.

I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and/or any insurance carrier or it's agents any information needed to determine the benefits payable for related services. I understand that my physician is not aware of all services covered under by Medicare and/or private insurance coverage. I have received a copy of the Notice of Privacy Practices.

I certify that I have read and understand the above information. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I authorize payment of medical benefits to Drew A. Stein, MD when assignment has been taken. I request that payment of authorized benefits be made on my behalf for the duration of my care to Drew A. Stein, MD. I permit a copy of this authorization to be used in place of the original.

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of this notice of privacy practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may separate written explanations of special privacy protections that apply to HIV-related information and mental health information.

Patient Signature: _____ Date: _____

Patient Name: (Please Print) _____