

## OFFICE POLICY

Maletta Pfeiffer and Associates

Payment for the Initial Evaluation is expected at the time of the evaluation unless there are prior arrangements. We will bill all primary insurance directly, however, payment for services rendered is always the responsibility of the patient. Each patient not having insurance, or for which the insurance plan will not provide payment in full, is required to pay at the time of service. By insurance regulation, a patient is responsible to pay all the deductible and coinsurance due. Therefore, any deductible that has not been met as well as the coinsurance (normally 20% of billed charge) is due at the time of each visit. Any other amounts not paid by insurers but due us will be collected at the time of service.

I have been informed of my co-pay/coinsurance responsibility [     ].

As a convenience to you we are more than happy to bill your insurance carrier. However, if payment is not received in a reasonable period of time, it is the responsibility of the patient to follow through with insurance companies regarding delay in payment(s).

We accept referrals from other practitioners besides medical doctors. However, insurance companies have refused to pay claims that have not been referred by a medical doctor. Therefore, you are responsible for services rendered upon receipt of service.

**Motor Vehicle or Other Liability Accidents:** Please provide this office all no-fault, liability or other accident information, requested on the registration form, so we can properly bill your insurance. If no-fault benefits are exhausted and your health insurance carrier will not approve continued treatment, you are responsible for payment at the time of service.

**Worker's Compensation:** In order for us to process these claims we will need a letter from your insurance company accepting responsibility for payment. If responsibility for payment is not received, the patient is responsible for payment at the time of service. Many times Worker's Compensation carriers approve a limited number of visits and without notice will reject further treatment. Anytime this may happen the patient is responsible for payment at the time of their next visit.

**Medicare:** We have contracted with Medicare, which means that we have agreed to accept Medicare payment for approved charges. This does not relinquish the patient's responsibility for payment, at the time of service, for the deductible or any treatments not approved by Medicare. Please provide us with the name and ID # for any MediGap insurance under secondary carrier on the registration form.

Office Policy (continued)

**Attorney:** If you have an attorney, please provide us with their name, address and phone number so we can send them a copy of the paid bill(s).

**Interest:** Interest at the rate of 2% will be charged on all balances over 90 days. Interest is compounded monthly and the annual rate is 24%.

**Collection:** Should your account be turned over for collection, a 25% surcharge will be added to cover the cost of collection as allowed by regulation.

**Cancellation of Appointments:** 24-hour advance notice is required. Please understand staff and space are allocated for your visit. If you do not show these costs are incurred by us. There will be a \$30.00 charge for late cancellations or missed appointments. This is not reimbursable by insurance companies and is the responsibility of the patient to pay at the time of his/her next visit.

**Credit Cards:** For your convenience we have provided for payment either through Visa or MasterCard. Please provide us with the name of your card, number and expiration date on the space provided on the registration form or the space provided below.

Name of Credit Card held by you:\_\_\_\_\_.

Credit Card #:\_\_\_\_\_ Expiration Date \_\_\_\_\_.

[  ] Photo ID Presented.

I understand the above information and agree to the terms stated above.

\_\_\_\_\_  
(Signature of insured and responsible party) Date \_\_\_\_\_.