Cesare P Peraglie MD FACS FASCRS

Financial Policy

Dear Patient:

Our office financial policies are as follows.

Medicare: This office is a participating provider with traditional Medicare. Your claims will be filed and you will not be held responsible for any services approved by Medicare other than your copayment, deductible, and non-covered services.

Secondary Insurance: This office will file your secondary insurance as a courtesy. Patients are responsible for communicating with their insurance carriers regarding disputes, non-payment and timely physician reimbursement. In the event your secondary had not paid with in 45 days, payment for services becomes the responsibility of the patient.

Waiver of Copayment: The office of the Inspector General strictly prohibits waiver to copayments. Although this provider accepts assignment that does not mean that there is no payment due after Medicare. Many secondary carriers do not pay the full amount of copayment, therefore, any balance remaining after your secondary carrier pays are your responsibility.

Managed Care Contracts: Due to the vast number of managed care contracts, you are responsible for ensuring services will be covered under your managed care contract. Copayment is due at the time of visit.

Professional Courtesy: The office of the Inspector General strictly prohibits professional courtesy.

I understand that my insurance coverage is a contract between my insurance company and me and I am solely responsible for any non-covered services or balances. I also understand that full payment is required upon receipt of my statement. If I am unable to pay in full, I agree it is my responsibility to contact the office and set up a payment plan. I understand that I am responsible for resolving any disputes regarding reimbursement not made by my carrier. I understand that even though my carrier may indicate services are above usually and customary, I am still responsible for payment to my physician. I understand that I am responsible for informing this office of any address change, insurance change or name change. I understand that if I receive a payment from my carrier that I will immediately forward the payment to the billing office. I authorize the above physician to release any information acquired in the course of my examination or treatment in order to file my insurance. I authorize payment for all services to be made to my physician.

I have read the above Financial Policy and understand my responsibilities as a patient. I have requested clarification of any part of this financial agreement that I do not understand.

Patient Name:_____ Date:_____

Patient Signature:_____