Dale R Traficante MD PA - FINANCIAL POLICY

WE REQUIRE PAYMENT IN FULL, which is **DUE AT THE TIME OF SERVICE**, unless we participate with your insurance company, or prior arrangements have been made. As your physician, my relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date service is rendered. You are ultimately responsible for knowing what is or is not covered by your insurance policy. Please notify us **prior** to your visit if your insurance changes. We realize that temporary financial problems may affect timely payment of your balance. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. Please ask if you have *any* questions or concerns regarding our Financial Policy.

Co-payments, Co-Insurance, and Deductibles are the result of a contractual agreement between you and your insurance company. These charges are not negotiable and are due on the date of service.

We accept Cash, Visa, MasterCard, Discover and American Express.

MEDICAID PATIENTS: please be advised that Dr. Traficante is **NOT** a Medicaid provider and can not bill for services rendered.

NO SHOWS / CANCELATIONS: We strive to be accessible to all of our patients. Please help us provide the best possible care by notifying us, in advance, if you are unable to keep a scheduled appointment. Preparation for in-office procedures and elective surgeries require significant staff time to set up. Failing to arrive when scheduled, affects more than just our staff, and increases medical costs for everyone. Any patient who fails to show up as scheduled will be charged as outlined below. This fee is not associated with your medical care and will not be billed to insurance. All no show charges must be paid in full before another appointment, procedure or surgery will be scheduled.

1) **Appointments:** You will be charged $25 for a missed appointment if not canceled at least 24 hours in advance.
2) **In-Office Procedures**: You will be charged $100 for a missed office procedure if not canceled at least 24 hours in advance.
3) **Elective Surgical Procedures**: You will be charged $200 for a missed surgical procedure if not canceled at least 48 hours in advance.

PAST DUE, LATE FEES, RETURNED CHECKS & REFUNDS:

***** Your account will be assessed 1.5% interest of the balance for outstanding balances over 30 days.
* Accounts aged 90+ days may be sent to collections or directly to a credit bureau and patient care may be suspended until debt is paid in full.
***** Should your account be sent to our collection agency for non-payment, your account will be assessed any/all fees incurred plus, an additional charge, up to 50% of the outstanding balance.
* Returned Checks: Your account will be assessed a service fee as outlined by the State Attorney for any check returned unpaid. Failure to make good on a returned check, within 15 days of notification, will result in the check being sent directly to the State Attorney for criminal prosecution. (we reserve the right to revoke check privileges for check returns)
* Refunds: refund checks will be generated on the 15th of the month once all outstanding insurance balances have been paid in full.

RECORDS / FORMS / LETTERS:

1) Medical Forms usually require significant staff/physician time to complete. We require a $10-25 fee, due when form is submitted and at least a 48 hour turnaround time for all forms to be completed
2) Medical Records are provided FREE of charge to any patient whose account is paid in full. We need 24 hours to get them prepared for you.
3) Medical Records to an attorney/insurance company will be provided for a fee in the amount of $1 per page. Payment must be made in full before records will be released.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE:

INSURANCE AUTHORIZATION

I request the payment of authorized insurance benefits be made on my behalf to Dr. Dale R. Traficante for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine theses benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the insurance carrier.

MEDICAID: (*if applicable)* **I** am aware that Dr. Traficante is NOT a Medicaid provider and I will be financially responsible for any benefits not paid by my primary insurance carrier.

SELF PAY: I am not filing any charges to an insurance carrier and will be financially responsible for any charges incurred for services rendered.

I, the undersigned, assign directly to Dr. Dale R. Traficante all medical benefits, if any, otherwise payable to me for services rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE, AT THE TIME OF SERVICE, FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

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Patient Signature Date

REV: 01/2017