

**Financial Policy**

Please ask if you have *any* questions or concerns regarding our fees or 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. You are ultimately responsible for payment and knowing what is or is not covered by your insurance policy.

***Co-payments, Co-Insurance, and Deductibles are due on the date of service.***

We accept Cash, Checks, Visa, MasterCard and Discover card.

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

**Missed Appointments:** You may be subject to a \$25 charge for missed appointments if appointments are not canceled at least 24 hours in advance.

**Insurance Changes:** Please notify us prior to your visit if your insurance changes or you will be held responsible for payment.

**Returned Checks:** Your account will be assessed a \$27.50 fee for all returned checks. (we reserve the right to revoke check privileges for multiple check returns)

**Past Due & Late Fees:**

- \* Your account will be assessed 1.5% interest of the balance for balances over 30 days.
- \* Accounts aged 120 days will be sent to collections and patient will be discharged from the practice.
- \* Your account will be assessed any/all fees incurred plus 50% of charges, should account be sent to our collection agency for non-payment.

**ASSIGNMENT AND RELEASE**

I, the undersigned, have coverage and 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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATION – if applicable**

I request the payment of authorized Medicare 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 these 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 Medicare carrier.

**MEDICAID \_\_\_\_\_**

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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date