MEHDI BAJOGHLI, M.D., P.C.
Financial Policy

Please read carefully. Your agreement to your financial responsibility is essential to proceed with treatment.

Thank you for choosing us as your health care provider. We will do everything possible to maintain the trust you have placed in our practice. Our receptionist is knowledgeable of many health plans, however, all policies are not the same and yours may have restrictions that only you can address. If you are uninsured, our billing department will be happy to make arrangement for installment payments if you qualify. Full payment is due at the time of service. We accept cash, personal checks and all major credit cards. There will be a $35.00 missed appointment fee if **24 hours** notice is not given to cancel an appointment. The return check fee is $30.00.

All patients are asked to complete a patient information which provides demographic and health information. We also ask that you provide information on your health care coverage. Otherwise, you will be responsible for filing your claims. If you belong to an HMO it is **your responsibility** to obtain the necessary referrals. Without them, you will be expected to pay in full on the date of the visit. If you are in a plan with which we do not participate, we will verify your out of network benefits, and you can determine if you wish to continue your care. Please remember that insurance plans are a contract between you and the company, we are not a third party to that contract. Allergy work up is usually covered under major medical insurances. We will be glad to submit a computerized claim form to your primary insurance at no charge to you. To avoid inefficiency and confusion, please understand that you and not your insurance company are responsible for medical bills. Therefore, we expect you to begin payment on your account when you receive the billing charges, if they send us a check and you have already paid the bill, we will credit your account or forward a reimbursement check to you.

Please Acknowledge the Following:

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. A copy of this authorization may be used in place of the original. I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this office for services rendered. I also shall notify this office for any change of my health insurance.

I understand and agree that I am financially responsible for charges, not my insurance company. I understand that I am responsible for the payments of all charges for services rendered, regardless of insurance. Most insurance companies process a claim within 30 days. Bills that have been processed through insurance over 90 days old are considered delinquent and will be sent to collections. Should the account be turned over to collections I agree to pay 33% collection fees.

Thank you for understanding our financial policy. Please let us know if you have any questions.
I have read and understand the Financial Policy.

X_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE