DIABETES & ENDOCRINE CENTER OF ORLANDO, P.A.

3113 LAWTON ROAD, SUITE 100 – ORLANDO, FL 32803

407-894-3241

FINANCIAL POLICY

Welcome to our practice. We are committed to providing you with the best possible care and are open to discussing our professional fees and policies with you at any time.

It is imperative that a current copy of your **insurance card and valid photo ID** is provided for accurate billing. Please bring your insurance card and photo ID with you to each visit. If you do not provide correct insurance information to the office, this may result in claims being denied for timely filing. If a claim is denied for timely filing, you may be responsible for all charges. In addition, it is extremely important for you to educate yourself about your individual insurance benefits. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

Insurance is a contract between you and your insurance company. We cannot become involved in disagreements between you and the insurance company regarding deductibles, co-payments, covered charges, etc. It is your responsibility to know if your insurance has a "participating provider list" and to verify if the doctors you see are on that list and understand how that affects your benefits. It is your responsibility to obtain required referrals and/or prior authorizations from your primary care physician (PCP) and to track the effective dates and number of visits authorized. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, or which they may consider medically unnecessary. In some instances you will be responsible for these amounts. We will make every effort to ascertain your coverage of our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the plan for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

Annual deductibles Co-payments/Co-insurance Charges for non-covered services

In the event we are not aware of a charge that is not covered by your plan, you will be billed after we obtain a denial from your insurance.

We are Medicare participating providers. We will bill Medicare and most secondary carriers (we do not participate with Medicaid). You will be responsible at the time of service for payment of :

Annual deductibles Co-insurance (no secondary insurance) Charges for non-covered services

If you have Medicare as well as secondary coverage, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental plan within 60 days after we file a claim, you will be sent a bill and will be responsible for the remaining account balance.

Our goal is to provide quality medical care to all of our patients. We do not discriminate against patients that do not have medical insurance; however, we do feel that it is important for uninsured patients to be aware of the following:

Self-pay patients must pay entire discounted amount at the time of service. An endocrine evaluation is specialized and generally requires additional diagnostic testing with either laboratory blood tests (that can run several hundred dollars or

x-rays/scans that can run into thousands of dollars). The fees for these tests are above and beyond the physicians charges. We do not have control over the cost of diagnostic testing and these services will be billed by the provider of service. Please understand that any tests ordered are required for us to evaluate and treat your medical condition. If you will not be able to comply with the testing, we will not be able to provide you with the level of care that an endocrinologist is expected to provide. In addition to diagnostic testing, prescription medications may be required and again we do not control the cost of the medications. The above information has been provided to avoid causing undue stress to any patient due to a financial burden that was not anticipated. We will provide the same quality care to all patients and believe that the financial and time burden is unfair, to both the patient and our practice, if the patient presents for the initial visit and then abandons care because they cannot proceed with the necessary diagnostic testing or prescription medications. Patients with past due balances must pay the entire past due balance, plus current days charges, prior to being seen. **If you are not able to pay at the time of check-in, we will need to reschedule your visit; and this visit will be considered a "no show".**

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. **Cancellations are requested 24 hours prior** to the appointment. There will be a **$50** charge for missed or late canceled appointments. Excessive abuse of the scheduled appointments will result in discharge from the practice. All accounts with patient balances that are not paid within 59 days will have a $10 statement fee added for each monthly statement that we mail.

Payments may be made with cash, personal check, Visa, MasterCard, or Discover. There is a $25 service charge for returned checks and if this occurs personal checks will no longer be accepted.

Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions.

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Credit Card Authorization **OPTION**

The information below may be added as a payment option (**not mandatory**).

My signature below allows this office to charge any outstanding balance to my credit card not to exceed $_____.

_____ ( )Visa ( ) MasterCard ( ) Discover

Name on card (PRINT)

_____

Card # Expiration Date

_____

Authorized Signature

I have read and understand the Diabetes and Endocrine Center of Orlando, P.A. Financial Policy. I agree to assign insurance benefits to Diabetes and Endocrine Center of Orlando, P.A. whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Print Patient Name Patient Signature Date