

Nephrology Associates
Of Syracuse, P.C.

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OUR FINANCIAL POLICY-2011

BASIC POLICY: Payments for services rendered are due in full at the time of service. Our office accepts cash, personal check, and credit cards (Visa, Mastercard, Discover and American Express). There is a \$20.00 returned check fee due and payable from you for each check payment returned to us by your bank.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will bill your insurance carrier, provided proper insurance information is provided to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. **Every effort will be made to closely estimate your co-payments and deductibles which are due at the time of service, but the ultimate responsibility of any unpaid balance rest on you. Please understand that insurance is a contract between YOU and YOUR insurance company.**

MANAGED CARE PATIENTS: Some benefit plans require pre-authorization and specialist referral forms from your primary physician. Please provide the proper insurance plan identification and forms necessary. All co-payments or out-of-pocket fees are due and payable at the time of service.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill your secondary insurance, if applicable. All co-payments and deductibles are due and payable at the time service is provided.

MEDICAID PATIENTS: All Medicaid patients must provide current necessary eligibility identification forms prior to being seen.

NON-COVERED CHARGES: All charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

INSURANCE/MEDICARE PATIENT: I request payment of authorized Insurance/Medicare benefits to be made either to me or on my behalf to **NEPHROLOGY ASSOCIATES OF SYRACUSE, P.C.** for services provided me.

I understand that my signature requests payment to 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 the release of information to the insurer or agency shown.

In Medicare-assigned cases, the provider 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 at the time of service. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

PRINT NAME:

SIGNATURE:

DATE:

If you are signing as the patient’s representative:

PRINT NAME:

DESCRIBE YOUR AUTHORITY: