OUR FINANCIAL POLICY

- **Office Visit** fees and any outstanding balance on account are due and payable in full at the time of your visit. As we do not participate with any insurance plans (accept for Medicare), office charges are not submitted to your insurance. An itemized receipt will be provided to you at the conclusion of your visit so you can submit to your insurance for reimbursement directly to you.
- If you are treated in the **Hospital**, we will bill your insurance for our professional charges with the information you provide us. As your insurance coverage is a contract between you and your insurance ***only***, payments may be sent directly to you and reimbursement may vary according to your individual policy. Some services may not be covered and only the member can appeal for any denials. You will be responsible for the ***full balance*** on your account within 30 days of billing including any deductible/co-insurance amounts and any balances not paid by your insurance.
- Personal checks are *not* accepted on the first visit. Payment may be made with cash, money order or valid major credit card (Visa, Mastercard, Amex, Discover).
- A payment plan may be arranged with the office manager on outstanding **hospital** balances only, *and* after all insurance payments received by the patient have been forwarded to our office.
- Check(s) returned by the bank for any reason will be assessed a $30.00 processing fee per check. Payments for continued care will only be accepted in cash, money order or a valid credit card.
- Any adult accompanying a minor is responsible for full payment of the office visit
- Non-emergency treatment will be denied to unaccompanied minors unless charges have been prepaid or pre-authorized in advance to an approved credit card.
- Pre-payment of fee and a signed HIPAA authorization form are required for processing and release of any medical records, copies of lab results, or any form which requires the Doctor's signature (disability, long-term insurance, etc). Please allow 2-3 business days for preparation and duplication.
- If an account is placed in Collections, the account holder will be responsible for all collection costs, including court costs and reasonable attorney fees.
- We attempt to confirm appointments as a courtesy only. Please notify our office at least 24 hours (one business day) in advance of any changes or cancellations, so that we may accommodate another patient who may need to be seen. A charge will be assessed for any missed or broken appointment without at least a 24-hour notice. Kindly be aware that three visits missed without a valid reason may result in dismissal from our practice.

I have read and fully understand the Financial Policy of Alan B. Schorr DO, FAAIM FACE. I hereby authorize this office to release any medical information to my insurance carrier necessary to process my claims. I authorize direct payment of medical benefits to this provider for charges not paid in full by myself. I understand that I am financially responsible for all charges for medical services rendered to me, or my legal dependent regardless of insurance coverage and/or payment.

Signature of Patient, Legal Guardian or Personal Representative Date

Print Patient Name, Legal Guardian or Personal Representative Date

Rev 10/10

Medicare Patients:

Please bring your Medicare and Secondary Insurance cards with you to every appointment at our office.

We Accept Traditional (Original) Medicare only**

(**No Medicare Advantage, HMO/PPO Medicare Plans.)

If Medicare is your primary insurance, we will bill Medicare for your office visit and for the doctor's treatments in the hospital.
During your visit, you will be expected to pay a portion towards your annual Medicare Deductible if it has not been met in full at time of your visit, along with the 20% Medicare Co-Pay amount, if not paid automatically to our office by a secondary insurance.

As per Federal Regulations, *please check applicable items and sign below:*

I am: __employed __unemployed __retired __disabled

___ I am 65 years of age or older and am covered by an Employer Group Health Plan (EGHP) through my own employer or that of my spouse.

___I am under 65 years of age and covered by Medicare due to disability.

___I am entitled to Medicare coverage due to End Stage Renal Disease.

___I am currently receiving Worker's Compensation Benefits

___I am covered through the Federal Black Lung Program

___I am covered by the Veterans' Administration Program

___I am currently receiving benefits due to No fault or Liability Case (i.e. Automobile Accident)

My Medicare Identification # (Health Insurance Claim number)_____
Name/Address of Secondary Insurance:_____
Subscriber Name_____ Relationship to patient: _____
Subscriber Social Security #_____Date of Birth_____
Policy#_____ Group#_____

PLEASE READ AND SIGN: I certify this information is true and complete to the best of my knowledge. I request that payment of authorized **Medicare/Medigap** Benefits be made either to me or on my behalf to Alan B. Schorr DO for any services furnished to me by this provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare &Medicaid Services/my Medigap Insurer, and their agents any information needed to determine these benefits or the benefits payable for related services.

_____

Signature of Beneficiary, Legal Guardian or Personal Representative Date

_____

Please Print Name of Beneficiary Relationship to Beneficiary or Patient Guardian or Personal Representative

Should you have any questions about our office policies, please don't hesitate to ask any member of our staff-we will be happy to assist you!