FINANCIAL POLICY FOR PATIENTS OF DR. NEIL HECHT

Payment in full is required at the time professional services are rendered unless other arrangements are made in advance.

Payment of deductibles, co-pays, and your unpaid insurance portion is required at the time professional services are rendered.

If you have medical insurance, your insurance will be billed. You are responsible for the unpaid portion after 30 days.

MEDICARE

If you have Medicare, you will be billed only for the unpaid portion of the Medicare-allowed services. Your co-insurance will be billed as a courtesy. Dr. Hecht is a participating Medicare provider. Federal law requires all patients be billed for the unpaid 20% of their Medicare-covered services and for their annual deductible of $155. (Exempt with valid Medi-Cal coverage.)

HMO

If you receive pre-authorized services, you are responsible only for your contracted co-payment.

ALL PATIENTS

I agree to allow Dr. Hecht to accept third-party payments from my insurance company, however, I agree to take financial responsibility for co-payments, deductibles, and any amounts not covered by my insurance company.

Please remember that insurance is considered a method of paying for health care costs. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. By your signature below, you hereby agree that it is your responsibility to pay any deductible, co-insurance, co-payment or any other allowed amount not paid for by insurance. Our office is not responsible for inaccurate or incomplete information supplied by you or your insurance company, and you accept full responsibility for payment should you or the insurer supply us with wrong, incomplete, or false information. In order to control our cost of billing, office co-payments, coinsurance and deductibles are due on the day you are seen.

I have read and understand the above-stated written financial policy and agree to pay for all professional services rendered as well as any collection and/or legal costs incurred due to non-payment.

Date: _____

_____

signature of patient, parent, or legal guardian

Please Note: We accept what your insurance allows as the correct fee if we are contracted with that company. This is not to be confused with what your insurance company may pay, as there may be additional co-payments, deductibles, and other co-insurance payments required from you.

$policy-revised 2010