Chitra Kuthiala, M.D., P.A. **Financial Policy**

As your physician, I am committed to provide you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment plan.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED

We accept cash, personal checks, MasterCard and Visa. Returned checks are subject to a $25.00 service fee and you will lose your privilege to writer checks to our office.

HMO/PPO INSURANCE COVERAGE

CO-PAYMENT AND DEDUCTIBLES MUST BE PAID AT THE TIME OF SERVICE.
Because we are under contract with these insurance companies, we will file your insurance.

MEDICARE

Your deductible and 20% of the allowable charges are due at the time of service; however, since we are Medicare providers we will file your Medicare. If we do not know the allowable charge for a specific service, you will be billed after payment is received from Medicare. Please bring your Medicare Explanation of Benefits to show that you have met your deductible.

WORKER'S COMPENSATION

We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance.

AUTOMOBILE ACCIDENTS

We will file your insurance claim when you are involved in an automobile accident; however, it is your responsibility to provide us with your insurance information so that we can verify coverage. You will be responsible for payment of your portion at the time you receive medical treatment.

LABORATORY BILLING PROCEDURE

I have been informed that all laboratory procedures done outside of the office (blood work, cultures, etc.) will not be included in the charges for Chitra Kuthiala, M.D., P.A.
All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory t the lab. Chitra Kuthiala, M.D., P.A. will send my lab specimens to a laboratory that accepts my insurance.

NO SHOW POLICY

There will be a $10.00 charge if you fail to show for your scheduled appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your appointment.

CONSENT FOR MEDICAL TREATMENT

I am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered necessary in the judgment of my physician or his/her designee for myself, my minor child or other. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as a result of treatment of examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

CHILDREN OF DIVORCED PARENTS

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, NO MATTER WHO IS RESPONSIBLE BY ORDER OF THE DIVORCE DECREE.

PRIVACY POLICY

I have received a copy of Chitra Kuthiala, M.D., P.A. privacy policy and have been given the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. yearly physicals and mole removals).

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

Collection action will be taken for any charges; including those that insurance has no paid, older than 90 days. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, Chitra Kuthiala, M.D., P.A.

_____ _____
Signature Date

_____ _____
Signature Date