Practice Financial Policy& Credit Card on File Authorization

Welcome to our practice! We are pleased that you have chosen us as your health care provider. Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our Authorization and Consent to Treatment Form before receiving medical services.

PATIENT RESPONSIBILITY
Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. We participate and submit Medicare claims.

TYPES OF PAYMENTS

1. Co-payments Insurance carriers require that we collect your co-payment at the time of your visit. If you are not prepared to make your co-payment, you may reschedule your appointment.

2. Deductibles Most insurance plans require you to pay a predetermined amount (the "deductible") before insurance will cover certain charges. We confirm the balance on your deductible and collect the appropriate amount at time of your visit.

3. Co-insurance Some insurance plans require that you pay a certain percentage (for example, 20%) of the allowable charge amount. Our technology allows us to view the details of your insurance plan, including your coinsurance amount, and calculate the expected out-of-pocket cost for you. We will ask that you pay your co-insurance at the time of your visit.

4. Uninsured Patients / Self-Pay If you do not have insurance or if the services provided are not covered by your insurance, payment for all services is due at the time of your visit.

5. Out-of-Network . You can contact your insurance company to confirm if your provider is in network prior to making your appointment. If we do not participate with your insurance plan, you will be required to pay for your visit at the time of service. We may send a courtesy bill to your insurance company.

6. Non-Covered Services It is your responsibility to contact your insurance plan to determine whether a specific service is covered. If we provide you non-covered services, you are expected to pay for the services at the time of your visit. If you are a Medicare patient, we will inform you of any non-covered services prior to your treatment. Your provider will review options with you and document your decision and acceptance of financial responsibility using the Centers for Medicare and Medicaid Services (CMS) form CMS-R-131 (03/08), Advance Beneficiary Notice (ABN).

Outstanding Balances After your visit, we will send you a statement for any outstanding balances. All outstanding balances are due upon receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance.

LATE ARRIVALS, CANCELLATIONS, AND NO-SHOWS

Late arrivals If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule.

Cancellations If you are unable to keep a scheduled appointment, you must call at least one (1) business day in advance or we may consider you a "no-show."
No-shows If you miss your appointment, you may be charged a $50.00 fee for a missed New patient appointment, a $45.00 fee for a missed follow-up appointment, This fee will need to be paid before you can schedule another appointment. This fee cannot be billed to insurance. If permitted by state law, you may be discharged as a patient following three (3) no-shows in a one-year period (365 days).

Assignment of Benefits I hereby assign benefits payable for the eligible claims to LJ Medical, LLC, who is submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I hereby state that the information provided is true and correct to the best of our knowledge.
I hereby understand the patient financial responsibility is due in full 5 days from billing statement date.
I understand that if my account becomes delinquent, I am responsible for the 30% collection fee.
I authorize direct payment to be made to LJ Medical, LLC for all services rendered.
I understand that if charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred and my credit card on file will be utilized for payment.
I have read, understand, and agree to abide by these guidelines.

Patient or patient representative Name / Signature Relationship Date

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Representative of LJ Medical, LLC Date

Credit Card on File Authorization

I authorize _____ to charge my credit card for the estimated patient responsibility at time of service, the patient responsibility after insurance claim processing identifies that amount that is my responsibility and all services not covered by my insurance carrier upon receipt of explanation of benefits by _____ This authorization will remain in effect until I cancel this authorization in writing and my account is in good-standing.

__AMEX __Visa __Mastercard __Discover __Debit Card

Credit Card Number _____

Expiration date ___/___/_____ Security Code _____

Cardholder Name _____

Signature _____ Date _____

Address _____

City_____ State_____ Zip _____

This authorization applies to the following patient(s):

Patient Name / DOB / Relationship

_____

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LJ Medical, LLC 5550 FRIENDSHIP BLVD STE 360 CHEVY CHASE MD 20815 (301) 917 4139