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THE DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY

A. LEE DELLON, M.D., P.A.

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FINANCIAL POLICY

We would like to thank you for choosing THE INSTITUTE FOR PERIPHERAL NERVE SURGERY as part of your health care team. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies and agree to abide by them.

Payment is expected at the time of service. This includes copayments or coinsurance for participating insurance companies. A. Lee Dellon, M.D., P.A., “The Practice” accepts cash, personal checks, VISA and MasterCard. There is a service charge of \$35.00 for returned checks.

The patient is responsible for any charges, or portion thereof, for which payment is denied by insurance, for whatever reason, except where prohibited by law or prior contractual agreement. Because it often takes months for The Practice to appeal a claim and receive a final decision regarding a claim from insurance carriers, the patient may receive a bill from The Practice months after a service was performed.

Insurance:

It is the patient’s responsibility to provide us with current insurance information and to present an active insurance card at each visit. If the patient presents false insurance information to The Practice, the patient will be solely responsible for the fees incurred, and payment will be expected in full.

It is the patient’s responsibility to provide a written referral for “specialist care” at the time of service, If his or her insurance policy requires this. It is not the responsibility of The Practice to know your policy requires a referral. If the claim is denied due to lack of referral – the bill will be sent directly to the patient and payment expected in full. It will be the patient’s responsibility to seek reimbursement from the insurance carrier.

If a patient is “OUT OF NETWORK” then the patient will be responsible for any and all additional fees not covered by their insurance carrier, except where prohibited by law or prior contractual agreement. The patient’s payment will be expected once the insurance carrier has determined their payment and The Practice has sent a bill for the balance of uncovered charges. The patient has the right to request AN ESTIMATE of what The Practice will charge. The

Practice is not bound by this ESTIMATE as it is meant only to provide a “ball park” figure. We will do our best to give an accurate ESTIMATE. All insurance companies vary in the costs they cover and therefore The Practice cannot Guarantee what percentage of the estimate the insurance company will pay.

Canceled Appointments:

If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. If you cancel a second appointment, then we reserve the right to charge \$25.00 for appointments that are not cancelled at least 24 hours in advance.

Past Due Accounts:

Patients with an outstanding balance over 120 days overdue must make arrangements for payment prior to scheduling their next appointment or procedure. Patients with outstanding balances over 120 days will be turned over to a collection agency, at the discretion of The Practice.

If The Practice has to turn an account over to a collection agency, the patient will be charged 10% interest on the outstanding balance from the date the bill was due and will be responsible for all costs and expenses of collection, including, but not limited to attorneys’ fees.

Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent a child from receiving the care they need at the time they need it.

SIGNATURE SHEET

Financial Policy

I have read, understand, and agree to the Financial Policy of A. Lee Dellon, M.D., P.A., dated 3/1/2011

X _____
Patient / Guarantor

Date: _____

Patient’s Name

Date of Birth

Assignment of Benefits

I hereby authorize A. Lee Dellon, M.D., P.A., to apply for benefits on my behalf for services rendered. I request and authorize payment from my insurer to be made directly to such physicians. The insurance information I have reported to you is correct and I authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company. A copy of this authorization may be used in place of the original.

X _____ Date: _____
Patient / Guarantor

Consent to Treat

I (or my legal guardian or parent) authorize "The Practice" (A. Lee Dellon, M.D., P.A.), to provide medical care reasonable by today's standards.

X _____ Date: _____

Patient / Guarantor

HIPPA / RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of A. Lee Dellon, M.D., P.A.'s Notice of Privacy Practice, which provides information about how we may use and disclose your protected health information.

X _____ Date: _____
Patient / Guarantor