Sunita Swamy MD PA

Financial Policy

Effective November 1, 2017 **Patient Name:_____**

Thank you for choosing Sunita Swamy MD PA as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due to us are recovered which will then allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible.

1. _____ I understand that my appointment may be rescheduled if I do not have proof of valid and current insurance, have not properly listed Dr. Swamy as my PCP if required, and / or I do not have the ability to pay my financial responsibility (co-payments, deductible or coinsurance rates) at the time of service.

2. _____ I understand that Sunita Swamy MD PA will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Sunita Swamy MD PA. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact Sunita Swamy MD PA at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ Should my insurance company request, it is my responsibility to provide my insurance company with the information needed to process a claim for services. It is also my responsibility to notify Sunita Swamy MD PA if there is any change in my insurance coverage, residence, or phone number. Ultimately, it is up to me to know my insurance benefits.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:_____ Date:_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Sunita Swamy MD PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ Date:_____