FINANCIAL POLICY **Gregory J. Liebscher MD, P.C.**

Today's Date _____ Date of Birth _____
Patient Name _____

We are committed to providing you the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policy. Please carefully review this information and sign/initial where indicated.

Current insurance cards must be presented to the office at each visit. Any changes to personal information must be given to the office immediately

I request that payment of authorized insurance, Medicare and Medicaid benefits be made payable to Gregory J. Liebscher, M.D., P.C.on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid

_____ **(Initial) I have read and agree to the above statement**

COPAY/ COINSURANCE/ DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by my primary and or secondary insurance. Tertiary insurance billing remains my responsibility. I am responsible for payment at time of service.

_____ **(Initial) I have read and agree to the above statement**

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to The Centers for Medicare and Medicaid Services, it's agents, my insurance carrier(s), or any other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Gregory J. Liebscher, MD, P.C. to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____ **(Initial) I have read and agree to the above statement**

REQUEST FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid

_____ **(Initial) I have read and agree to the above statement**

SELF-PAY: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payment are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

_____ **(Initial) I have read and agree to the above statement**

PATHOLOGIES/ LABS AND OTHER SERVICES: I understand I am financially responsible for all pathology and lab charges that may arise from surgery.

_____ **(Initial) I have read and agree to the above statement**

SURGICAL CANCELLATION POLICY: I understand if I cancel my surgery within two weeks of my scheduled surgery date I forfeit my surgery deposit

_____ **(Initial) I have read and agree to the above statement**

RETURNED CHECKS: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

_____ **(Initial) I have read and agree to the above statement**

PRIVACY POLICY: I have been made aware of the privacy policy of Gregory J. Liebscher, MD, P.C. and have received (or reviewed or given the option to receive and review) a copy of the Notice of Privacy Practices, (aka HIPPA Form)

_____ **(Initial) I have read and agree to the above statement**

I have read and agree to the above information and I, the undersigned/ patient, am ultimately responsible for fees. By signing below, I consent to be contacted by regular mail, by email or telephone (including cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any Assignment:updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/ or prerecorded messages. Your attending physician may have an ownership interest in one or more Ambulatory Surgery Centers. Please contact office personnel if you have any questions.

PRINT NAME _____

Office Use Only Initial _____ Date _____

SIGNATURE _____ **DATE** _____

Office Use Only Initial _____ Date _____