Haydee Docasar, M.D.

www.haydeedocasarmd.com

FINANCIAL POLICY

Welcome to *Dr. Docasar's office*. The following outlines the patient financial responsibility policy.
Payment for services provided by *Haydee Docasar, MD* is required at the time of services unless prior arrangements have been made. **Co-pays, co-insurance, deductibles, and/or non-covered services are due at the time of service, no exceptions.** If we are contracted with your insurance company, we will bill your insurance company as a courtesy to you. Understand that it is ultimately your responsibility as the patient to know your insurance coverage. We encourage every patient to know their medical benefits, if you need further clarification contact your insurance company directly. Although, Dr. Docasar does contact your insurance company monthly for benefits, please be aware that benefits quoted to Dr. Docasar is not a guarantee of benefits and/or payment. Co-Insurance and allowable information given to Dr. Docasar is an estimate and further payment may be required after your claim has been paid. Exact payment is not determined until your claim is process by your insurance company.

Initials _____

Please understand that as your medical office we are not obligated to send out statements. We do this as a courtesy to the patient. As a patient you should receive an EOB from your insurance company that will indicate what the insurance company paid on a specific claim and what they did not pay which in turn would be owed to the medical office. After 90 days, if we haven't heard back from your insurance company on any insurance claim that has not been paid by the insurance company, we will provide you with a HCFA and proof of timely filing to send to your insurance company to help you get the claim paid. The charges will be turned over to you as the patient.

Initials_____

All medications and medical supplies provided by any of the physicians should be completely paid for at the time of service. Services provided by outside laboratories such as the reading of PAP tests and/or biopsies will be **billed directly to you by the outside laboratory**. If you need to be referred to a specific laboratory or cytology lab, it is your responsibility to communicate this information to the physician.

Initials _____

If *Haydee Docasar, MD* is **not contracted** with your insurance company and you need a medical service, we will provide you with our cash 20% discount to help you estimate the cost of your medical services. A financial agreement form will be completed which should include the cost of the service. Financial arrangements can be discussed in advance so that a specific payment plan can be arranged, if necessary. All fees are required to be paid in full prior to service. You can use your out of network benefits if they are available if you choose.

Initials _____

6785 W Russell Road Ste. 130 Las Vegas, Nevada 89118
Tel: 702-550-4870 Fax: 855-898-8685
Email: Info@haydeedocasarmd.com

Haydee Docasar, M.D.

www.haydeedocasarmd.com

Our statements show in detail charges incurred during the statement period and the amount due. Any uncollected fees are **payable within 15 days** of receiving the statement. You are responsible for complete payment of any charges that you incur whether covered by your insurance or not covered by your insurance. A finance charge of **1.5%** per month or **18%** annually will be incurred 30 days following the date of the services were provided. If your account becomes delinquent or referred to a collection agency, you will be responsible for the costs of collection and/or legal fees. All accounts that are 90 days past due will automatically be assigned to a collection agency, regardless of insurance coverage. Accounts assigned to collections will include a **35%** collection and processing fee.

Initials _____

There will be a **$50.00 cancellation fee** for all appointments not cancelled within 48 hours of the appointment. A fee of **$100.00** for all in-office procedural appointments not cancelled within 48 hours of appointment. A **$100.00** fee will be charges for all re-deposited, returned checks or stop payments.

Initials _____

I authorize Dr Docasar to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I further authorize my insurance company and its carriers to disclose any information requested regarding claims for medical benefits to Dr Docasar. A copy of this authorization may be used in place of the original.

Initials _____

I request that payment of authorized medical benefits be made on my behalf to Dr Docasar for services furnished to me, any physician covering for the care of her patients, or her staff unless I have paid for the services and will be billing the insurance company directly.

Initials _____

. I understand that the office of Dr. Docasar will take cash, check and credit card as forms of payment. I understand I will be providing a credit card on file to cover any expenses not covered by my insurance and will only be used to cover my balance under $100.00 including NO SHOW FEES

Initials _____

Your signature below indicates that you understand and agree to this financial policy. You also are acknowledging that you have read and/or received a copy of this practices ***NOTICE OF PRIVACY PRACTICES.***

Signature of Patient: _____ **Date:** _____

Signature of Parent/Legal Guardian: _____.

6785 W Russell Road Ste. 130 Las Vegas, Nevada 89118
Tel: 702-550-4870 Fax: 855-898-8685
Email: Info@haydeedocasarmd.com