

Insurance information provided is not a method of payment. We process the insurance claims for you but **you are responsible** for payment of services received. Professional services (charges) are due and payable at the time service is rendered. This includes urgent work-in visits. All accounts are on a 30-day basis. There is a \$20.00 service fee on all returned checks; please note NSF checks are not redeposited. Visa & Mastercard are accepted.

If you are experiencing difficulty collecting reimbursement from your insurance company, we will be happy to assist you. However, **this office is not responsible for your insurance company**; your policy is an agreement between you and your company.

For surgical procedures it is the patient's responsibility to inform our office if your insurance needs prior authorization, second opinion or requires you to go to an authorized facility.

All HMO/PPO plans with deductibles and/or co-payments are required to pay these at the time of service. **For the HMO/PPO plans of which we are not providers, it is the patients responsibility to obtain written authorization prior to scheduling any appointments.**

Insurance Patients

Acceptance of insurance assignments by this office does not absolve the patient of responsibility for charges in full treatment rendered. All charges are the direct responsibility of the patient. For your convenience, we prepare and submit the necessary reports to the insurance companies, providing we have accurate, updated insurance information. If we are unable to verify coverage or your insurance company does not pay within sixty (60) days, we require payment from the patient. **A monthly finance fee of 1.5% will also be charged until the account is paid in full.**

A \$10.00 service fee per form is required prior to the the completion and mailing of disability forms, excluding state disability.

A \$20.00 no show fee will be billed if 24 hour notice is not received.

We appreciate your cooperation in adhering to our above policies.

ASSIGNMENT OF BENEFITS

I hereby authorize WILLIAM BARGAR, M.D. & THOMAS J. BLUMENFELD, M.D. to furnish to my insurance(s) all information which said insurance company(s) may request. I hereby assign to WILLIAM L. BARGAR, M.D. & THOMAS J. BLUMENFELD, M.D. all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the insurance company(s), over and above my indebtedness, will be refunded to me when my bill is paid in full.

This assignment shall remain in effect until revoked by me in writing. A photocopy shall be considered as void as an original.

Signature of Insured: _____ Date: _____

I authorize the reslease of any necessary medical information from William L. Bargar, M.D. & Thomas J. Blumenfeld, M.D. to the referring physician or any physicians which become involved in my care and may require records for appropriate medical care.

Signature of Patient: _____ Date: _____