GEORGE MED-PEDS ASSOCIATES. P.C.
PO BOX 82227
LAS VEGAS, NEVADA 89180-2227

OFFICE FINANCIAL POLICY

BASIC POLICY: Payment for service due in full at the time of service.
FOR PATIENTS WITH INSURANCE: As a convenience to our patients, we bill most insurance carriers for you. We will also bill most secondary insurance companies for you. Co-payments and/or deductibles are due and payable at the time of service. If an insurance carrier has not paid within 60 days of billing, payment is due in full from you. Accounts past due 90 days will be sent to collections with a $50 processing fee.
MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance for you. All co-payments and/or deductibles are due and payable at the time of service.
WELFARE PATIENTS: All welfare patients must provide a current, valid sticker or Nevada card before being seen.
NON-COVERED SERVICES: You are responsible for payment in full of all items that are deemed non-covered services by your medical insurance plan.
WORKER'S COMPENSATION: If your injury is work related, you must supply us with the name, address and phone number of your employer; the name of the Worker's Compensation Carrier, the case number and authorization number prior to your visit in order to bill the worker's compensation insurance company.
YEARLY HEALTH CHECKS: Periodic preventative health checks may or may not be covered under your medical insurance policy; however, they may be required by your physician.
MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least **24 hours notice to cancel appointments**. You will be charged a fee of **$50** for missed appointments. Frequently missed appointments may call for dismissal from our practice.

PLEASE CHECK ONE: I have paid my insurance deductible for the calendar year 20___ O YES O NO O DON'T KNOW

ASSIGNMENT OF INSURANCE BENEFITS: Patients with medical insurance coverage, please read and sign below.
I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **George Med-Peds Associates, P.C.** 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 information necessary to secure the payment.

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS: SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made either to me or on my behalf to **George Med-Peds Associates, P.C.** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print): _____	**PROVIDER GROUP**
Patient's Signature: _____	**George Med-Peds Associates, P.C.**
Patient's Medicare Number: **Date:** _____	

In order for us to file your claims, you must provide us with current information about every medical plan that you have, including private plans, employer plans, managed care plans, HMO,PPO,POS plans, state, federal and military plans, and any other type of medical plan you might have. Medical claim requirements vary based on the type and number of medical plans you have. Even if you believe a particular plan will not pay anything for this service, you must still provide us with current information about the plan or we cannot correctly file and medical claims for you.
You must allow us to make a photocopy of the front and back of each medical plan ID card / state driver's license / state ID card / current military ID card (Those with medical plans of TRICARE/CHAMPUS or CHAMPVA.). You must provide us with your birthdate / Social Security number and the birthdate / Social Security number of the policyholder for each plan. We only use Social Security numbers for filing your medical claims and collecting payment due. We do not use Social Security numbers for any other purpose. If the information you provide is incorrect or if your medical plan has expired, you will be responsible for payment in full.

I have read, understood and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees. (Responsible party must sign if patient is younger than 18 years of age.)

PATIENT / RESPONSIBLE PARTY PRINTED NAME: _____ DATE: ___/___/____

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____ DATE: ___/___/____