PETER C. BRASCH, M.D., L.L.C.

FINANCIAL AND PAYMENT POLICY

Please read the following regarding our financial and payment policy and sign below:

It is the policy of Peter C. Brasch, M.D. L.L.C. that **the patient has the ultimate responsibility** for payment on his or her account. Payment in full is due and required at the time of service.

Insurance – In an effort to accommodate the needs of our patients, we have contracted with Medicare and many other insurances. The specifics of your plan that govern how claims are paid are outlined in the policy booklet you received when you joined the insurance plan you elected. It is your responsibility to read and understand your insurance plan's provisions and requirements. If we are not contracted with your current insurance it will be necessary for you to pay in full for your visit at the time of service. We will provide you with an itemized receipt that you can send to your insurance company for them to reimburse you.

If your insurance requires a referral or authorization from your primary care physician (PCP) it is your responsibility to make sure that the referral is in our office at the time of your visit. If no referral is obtained you may be required to reschedule your appointment, or be prepared to pay for the visit in full.

If your insurance plan requires a specialist co-pay, that co-pay is due at every visit and is not an option. If you cannot pay your co-pay, be prepared to reschedule your appointment. It is also a requirement that costs not covered by insurance, co-insurance and deductibles be paid at the time of service.

If you do not have your insurance card or insurance information with you at the time of your visit, be prepared to pay in full for the visit, or to reschedule your appointment. If you need assistance or have questions about your insurance card or our policies, please ask our receptionist or biller.

Self-Pay Patients are required to pay for services at each visit.

If your account becomes delinquent for noncompliance to our financial policy, and we feel it is necessary to involve a third party in the collection effort, we reserve the right to add a collection fee to your balance.

I have read, understand, and agree to Peter C. Brasch, M.D. L.L.C,'s financial and payment policy.

I understand that charges not covered by my insurance company, as well as applicable co-payment, deductible, and out-of-network fees are my responsibility. In the event my account becomes delinquent I understand and agree to pay the collection fees and or attorney fees associated with the collection process. Failure to follow our policy may result in discharge from our practice. Peter C. Brasch, M.D. L.L.C. will not deny emergency care.

Please bill my _____insurance for today.

Patient Name: _____

Signature: _____ Date: _____

American Board Certified Ophthalmologist

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