Mark D.Le M.D.,P.A.
Medical Clinic

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FINANCIAL RESPONSIBILITIES AND POLICIES AGREEMENT

Thank you for choosing Mark D. Le M.D.,P.A. for your medical needs. The following patient financial responsibilities and policies have been established to assist us providing the highest quality medical care.

Insurance: It is your responsibility to know and understand your coverage and benefits. As a courtesy, we will file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth and relationship to the patient to file all claims. Patients are responsible for all fees that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received. **At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly.**

No Insurance: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service.

Returned Check: There will be a twenty five dollar ($25.00) charge assessed for any check returned.

Collections: Accounts that are not paid within sixty (90) days from the date of service may be sent to collection. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Refunds: If you have a credit on your account, we will gladly refund the amount within thirty (30) days of your request. You must provide a correct mailing address for your refund to be sent.

Dismissal Process: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

a) Failure to keep scheduled appointments
b) Being verbally or physically abusive to staff
c) Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty (30) days of the date of the letter, one of our providers will see you. After the thirty (30) days, you will no longer be seen at our practice by any provider. A copy of your medical record may be forwarded to your new doctor after a formal request is made and appropriate fees are paid.

Patient Acknowledgement:

I, _____ (print name) have read and agree to the **Patient Financial Responsibilities and Policies.** I agree to pay at the time of service. I also understand that Mark D. Le M.D.,P.A. reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.

Signature of Patient/Legal Representative		
_____	_____	_____
Signature	Date	Relationship to the Patient