Azelvandre D.O. & Associates, LLC

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Financial Policy

This is an agreement between Azelvandre D.O. & Associates LLC, as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are renderec We accept cash, personal check, money orders cashier's check, Visa and Master Card. We collect copay, coinsurance and any deductible at the time services are rendered.

Insurance:
Insurance is a contract between you and your insurance company. We will file insurance claims **only** for plans with whom we have a contract with. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front & back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All copay, coinsurance and deductibles are due at the time services are rendered.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

Collection fee: A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

Termination: If your account is sent to collections the account will be automatically terminated. You will have to find another Primary Care Physician.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee currently of $25.00 for any checks returned by the bank. Payment made on a returned check must be mad In cash or by a money order.

Copying of records: You will need to request in writing, and pay a reasonable copying fee ($1/page for the first 25 pages and 25 cents for every page thereafter) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all releva information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Effective date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be i full force and effect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents on this form.

Patient's name printed: _____ **Date:** _____

Patient's signature: _____

Responsible party (if not the patient): _____