

Last Name, First Name, MI _____ Date Of Birth _____

**Dr. Bruce V Lattyak
Financial Policy**

Thank you for choosing Dr. Bruce Lattyak as your health care provider. We are committed to your treatment being successful.

INSURANCE:

We have entered an age of extreme complexity in regard to the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on you. This includes, but is not limited to, knowing which facilities can be used for laboratory, hospitalization, or outpatient surgery. Also, it is critical that you notify our staff of any insurance changes you may have.

The patient is responsible for co-payments, deductibles, non-covered services and/or amounts that the insurance denies. If you have HMO insurance, we ask that you obtain a referral from you primary care physician before you schedule an appointment with our office.

We are not contracted with the following insurance companies: **Medi Cal, United Healthcare, CMSP, and some Healthy Families** policies. If you have one of the above mentioned insurance companies, we will collect \$150.00 for today's appointment and we will still bill your insurance as a courtesy to you. You will be financially responsible for any portion of your bill that your insurance company does not pay.

MEDICARE:

You are responsible for paying your **20% co-payment** and any amount applied to your annual Medical Part B deductible at the time of service.

SELF-PAY/CASH:

If you do not have insurance accepted by Dr. Lattyak, you are required to pay **\$150 when checking in for your appointment**. This will be applied to your account for payment of that day's visit with Dr. Lattyak. If you have a medically necessary procedure at the hospital, you are responsible for **100% of the surgeon's fee** at the time of the pre-operative appointment (usually 1 week prior to surgery).

UNPAID BALANCES:

You will be charged 18% APR interest in addition to the principal on balance over 60 days due. After 90 days, delinquent accounts will be sent to a collection agency.

CANCELLATION POLICY:

Appointments which are not kept or which are canceled without 24 hours notice may be charged a \$75.00 fee which cannot be billed to your insurance. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and may be discharged from the practice.

I understand that medical insurance plans vary and there may be limitations and exclusions in my plan of which I or Dr. Lattyak may not be aware. I also understand that actual benefits can be determine only by my insurance company and only after a claim is filed. This applies to all medical coverage including Medicare and Medical. I agree to be responsible for the charges not covered by my insurance plan.

Patient: _____ D.O.B. _____

Subscriber Name: _____

Relationship: _____

Signature: _____ Date: _____