FINANCIAL POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to contact our billing office with any questions regarding filing of insurance and your financial obligation to Dr. Srivastava.

Please initial by each paragraph below indicating that you have read and agree to each.

***Initial*_____** Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to the contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charge. As your medical provider, we will only supply information to facilitate claim processing.

***Initial*_____** All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed for SelectSkinMD, you recognize an obligation to promptly remit payment to SelectSkinMD.

***Initial*_____** Dr. Srivastava is a participating provider for MEDICARE, UHC, CIGNA, BLUE CROSS/BLUE SHIELD (except HMO) insurances. If you have insurance coverage that is not one with which we are a provider, we will file your insurance **once** as a courtesy, however, if they do not pay within 30 days, any balance due will be your responsibility. **If you have a co-pay stated on your insurance card, we will collect that at the time of your visit.**

***Initial*_____** I authorize release of information concerning healthcare, advice, treatment to my insurance company(s), other physicians' offices where I am a patient, a physician's office that I am being referred to or to a surgical facility in preparation for surgery.

***Initial*_____** I understand that it is my responsibility to notify the office if my medical insurance coverage, claims address, or medication information changes.

I, the undersigned, authorize payment of medical benefits for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I agree to be responsible for any legal fees and / or court costs incurred as a result of my failure to pay for services rendered.

Please print Patient's Name: _____ Date: _____

Patient's or Parent/Guardian Signature: _____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Srivastava for any services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine if these benefits are payable for related services. The Medicare provider, Dr. Monika Srivastava agrees to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed:_____ Date: _____