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Payment Policy effective 06/20/2006

Thank you for choosing me as your primary care provider. I am committed to providing you with quality and affordable health care. Because some of my patients have had questions **regarding** patient and insurance responsibility for services rendered, I have been advised to develop this payment policy. Please read it, ask me any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. I participate in most insurance plans, including Medicare. If you are not insured by a plan I do business with, payment in FULL is expected at each visit. If you are insured by a plan I do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until I can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on my part to collect co-payments and deductibles from patients can be considered fraud. Please help me in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in FULL at the time of visit. Examples of non covered services are: missed appointment charges (\$35), returned check fee (\$25), completion of forms (\$10).

4. Proof of insurance. All patients must complete my patient information forms before seeing me. I will obtain a copy of your driver's license and current valid insurance card to verify your insurance. If you fail to provide me with the correct insurance information in a timely manner, you will be responsible for all or part of the claim.

5. Claims submission. I will personally bill your insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; I am not party to that contract.

6. Coverage changes. If your insurance changes, please notify me before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, the balance will automatically be billed to you.

7. Nonpayment. Please be aware that if a balance remains unpaid, I may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, I will only be able to treat you on an emergency basis.

8. Missed appointments. My policy is to charge for missed appointments not canceled within a reasonable amount of time. The charge will be \$35.00 per missed appointment. These charges will be your responsibility and billed directly to you. Please help me to serve you better by keeping your regularly scheduled appointment.

9. Payment Plans. If you are experiencing financial hardship, please discuss this with me prior to your appointment. We may be able to work out a payment plan.

I am committed to providing the best treatment to my patients. My prices are representative of the usual and customary charges for our area. Thank you for understanding my payment policy. Please let me know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date