ROOPALI, M.D., F.A.C.O.G., 638 LAWRENCE RD., LAWRENCEVILLE, NJ 08648 Tel. (609) 883-8200;Fax (609) 530-1881

FINANCIAL POLICY

Dear Patient,

Thank you for choosing this practice as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which must be read and signed prior to any treatment.

All patients must complete our patient information form and present any necessary insurance cards, forms, or referrals before seeing the doctor. Any existing patients with changes in information (addresses, phone numbers, insurance information) must complete a new information form or advise the receptionist of such changes . This is very important, as important notices concerning your health may be lost if we do not have current information as to your whereabouts.

Please Note The Following:

1. **FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE**
2. **PAYMENTS MAY BE MADE IN CASH, CHECKS, MONEY ORDERS, OR VISA/MASTER CARD**
3. **WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL**

INSURANCE

Please take some time to read our policy on medical insurance plans. Your signature below indicates your understanding and acceptance of our medical insurance policy. Please feel free to discuss any questions with our office staff.

PRIMARY INSURANCE

Primary insurance is coverage through YOUR employer or your spouse if you are not employed.

SECONDARY INSURANCE

Secondary insurance is additional coverage through a spouse. Children with coverage through both parents will be considered to be primary under whichever parent's birthday falls first in the calendar year.
If our office participates with either your primary or secondary insurance, we will submit the claim as appropriate and it is your responsibility at the time of service to provide our office with the following:

1. All information that applies to the primary insured including date of birth and social security number
2. The insurance claim submission address for both insurance companies
3. The co payment as required by your insurance company
4. Persons covered under other commercial insurance will be required to pay at time of service; an insurance claim will then be filed to your company, which should reimburse you at their payable rate. This change is due to multiple problems with commercial insurance companies regarding failure of payment in the past.

REFERRALS

PLANS REQUIRING REFERRAL

1. If you need a referral for a visit we cannot see you without one.
2. For plans requiring referrals you must have a valid referral, which must be presented prior to service to qualify for your insurance benefit
3. If you choose to be seen without a valid referral, you must understand that any charges incurred resulting from this visit will be your responsibility. As per your contract with your insurance carrier, you have agreed to bring a referral coordinated by your Primary Care Physician to be treated by a Specialist. We will submit to your insurance carrier and then bill you preferred provider rates as per the Insurance Explanation of Benefits.

POS PLANS

For plans requiring referrals for maximum or optimal benefits (POS or Point of Service Plans), we do not require a referral, however, it is the responsibility of the insured to be aware of their insurance benefits. If you choose to be seen without a referral, you will be responsible for all the deductibles or charges as per your contract with your insurance company. We will submit charges with a referral when provided to us. We will submit to your insurance carrier and then bill you, if necessary, as per the Explanation of Benefits we receive from your insurance company.

COPAYS

Exact change for copay is needed at the time of service.
We will bill 1½ times for copay if not paid on the day of service. Billing cost is too high for investing time for such a small amount.

INSURANCE WE ACCEPT

Except for persons covered under the Horizon, Cigna, PHCS, United Health Plan, One Health Plan, Oxford, or other office-contracted insurance plans, no commercial insurance plans will be accepted for coverage of office visits and pregnancy-related visits

FOLLOWING CLAIM SUBMISSION

Following claim submission, you will be billed for any deductibles or co payments your insurance company notifies us is your responsibility. Payment is expected upon receipt of statement from our office.

PAY PROMPT ATTENTION TO INFORMATION REQUESTED BY YOUR INSURANCE

Occasionally, insurance company will request information from you regarding medical claims. You must respond to these inquiries within 14 days, or you may be held responsible for the entire charge of the medical visit.

DEDUCTIBLE

Please know your exact deductible, whether met or not, please furnish proof of payment in full towards it or pay it prior to be seen unless we participate with your insurance.

We may accept assignment of insurance benefits depending on the specifics of your company's reimbursement policy and any outstanding deductible that you may have. However, we require at least 50 % of the bill to be paid at time of service. Balance is your responsibility whether your insurance pays or not. We cannot bill your insurance unless you bring in all insurance information and/or an original claim form.

Please note that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we accept assignment of benefits, and your account is not paid in full by the insurance company in 45 days, the balance will be automatically transferred to your responsibility for payment; we will require a valid Master Card/Visa for this purpose if assignment is desired. Please be aware that some and perhaps all provided service may be non-covered services and not considered necessary under your particular plan by its managers. In the event we do not accept assignment of benefits, we require that you be pre-approved on our extended payment plan with authorization to bill that account within 45 days, the balance of your account will be transferred to your extended payment plan.

PAYMENT FOR SERVICES

Adult Patients are responsible for full payment at time of service. For minor patients, the accompanying adult and parent/guardians will be responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre authorized to a major credit card, cash or check at time of services. Payment of any charges may be made by Master Card, or Visa as well as by cash, check, or money order . Any payments made by check which do not clear the bank due to insufficient funds or closed accounts will result in a cash-only basis for all subsequent visits and assessment of penalty fees on the amount due. We will accept check in payment for balances due on the condition that:

A) The name and address of the account owner appear on the check;
B) Identification in the form of a driver's license or major credit card (Master Card, Visa) is presented.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Co-payments for particular plans are established by the plan itself and are payable at time of service.

PAYMENT DELINQUENCY

We will bill your insurance company in order to obtain payment in a timely fashion. However, the Prompt Pay Law of the state requires that Insurance companies pay a claim in 30 days or less from the date of submission. After 60 days of such billing attempts, we request that you pay your balance and seek reimbursement from your insurer. An interest charge of 1 ½ % per month will be added to all bills older than 60 days; any outstanding balance beyond 75 days will be forwarded to a collection agency for further collection efforts without further notice. Please avoid any unpleasant encounters and possible credit damage by paying outstanding balances promptly.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed office appointments at the rate of $25.00 per visit missed; missed surgical appointments will be charged at the rate of $25.00. Please notify the office PROMPTLY if you find yourself unable to attend an appointment; you may call during regular office hours (Monday through Friday, between 10:00am and 3:00pm). Avoid leaving a message with the answering service during off hours for the receptionist. If you leave a message, please follow up with a phone call during office hours. If you will be more than 15 minutes late for an appointment, please call the office to inform us.

LATE POLICY

This office reserves the right to re-schedule any patient who arrives fifteen (15) minutes late or more for a scheduled appointment. We will make every effort to re-schedule at the next earliest appointment.
This policy will help us to provide courteous service to all our patients.

PATIENT GOING OUT OF NETWORK

I am aware with my insurance that I am going out of network and will be responsible for any balance not paid by my insurance.

Patient _____ A/C _____

Witness _____ Date _____

SIMPLE AGREEMENT FORM

Patient authorizes the doctor to deposit checks received on Patient's account when made out to the Patient.

Patient Signature: _____ **Date**: _____

Thank you for understanding our Financial Policy. Please inform us if you have any questions or concerns.

Sincerely Yours,

B. Roopali, M.D.

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I have read the complete Financial Policy and understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on all sides of the sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

X_____ **Date** _____
Signature of Patient/Guarantor

X _____ **Date** _____
Signature of Co-Responsible Party

B. ROOPALI, M.D., F.A.C.O.G.
638 LAWRENCE RD.
LAWRENCEVILLE, NJ 08648
TEL. (609) 883-8200 * FAX (609) 530-1881

DATE _____

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to:

B. Roopali, M.D.
638 Lawrence Rd.
Lawrenceville, NJ 08648

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ This _____ day of _____, 20 ____

_____ _____
Signature of Policyholder **Witness**

_____
Signature of Claimant, if other than Policyholder