Lamorinda ENT, Face and Neck Surgery, Inc.
Sassan Falsafi, MD, MSChE
Diplomate of the American Board of Otolaryngology, Head & Neck Surgery

Financial and Payment Policy
Non-Medicare Patients Only

BASIC POLICY Pay for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE: If you are insured please provide our office with your current insurance card(s) every time you come in for a visit. If you do not have insurance, payment in full shall be collected at time of service. If you have a financial hardship, a payment plan can be arranged through our billing office. Please call ahead of time: **(925) 299 - 9919**. As a courtesy, our office will bill your insurance(s) and do all the paper work for you. We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. You or your insurance may be billed for consultations, completion of forms and writing letters as determined by the provider.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

WELFARE PATIENTS: All welfare patients must provide a current, valid sticker before being seen.

SURGERY FEES: All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier. Surgeries cancelled later than two weeks from surgery date are subject to a $250 fee. This fee is transferable to a future date if surgery is rescheduled.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

WORKER'S COMPENSATION: If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.

YEARLY HEALTH CHECKS: Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we required at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

_____ _____

Signature of Patient or Legal Guardian if Patient is a Minor Date

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OTHER FEES:

- A $10.00 Fee for Non-payment of co-pay will be charged in addition to your co-pay if you are unable to pay at the time of service.
- A $20.00 re-bill insurance Fee will be charged if you provide our office with incorrect insurance information at the time of service.
- A $50.00 fee will be charged for all cancelled appointments without a 24 hour advance notice during work days. Monday appointments need to be cancelled no later than the prior Thursday.
- A $50.00 fee will be charged for NO SHOWs.
- A $25.00 RETURNED CHECK Fee will be charged to your account for all non-sufficient fund checks.
- A $250 **Non-refundable** deposit is required to book surgeries. This will be applied towards your surgical fees.
- A $35 administrative fee will be charged for production and release of your medical records.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurances please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to _Lamorinda ENT, Face & Neck Surgery_. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Please check on: I have paid my insurance deductible for the calendar year _____ □ Yes □ No □ Don't know

The patient is ultimately responsible for all professional fees.

I have read, understand and agree to the above policies regarding privacy and responsibility for payment of professional services.

_____ _____

Signature of Patient or Legal Guardian if Patient is a Minor Date

Lamorinda ENT, Face & Neck Surgery, Inc. | 911 Moraga Road | Suite 102 | Lafayette, CA 94549
Tel: 925-299-9919 | Fax: 925-299-9924 | Email: contactus@lamorindaent.com

Lamorinda ENT, Face and Neck Surgery, Inc.

Sassan Falsafi, MD, MSChE
Diplomate of the American Board of Otolaryngology, Head & Neck Surgery

Financial and Payment Policy
Medicare Patients Only

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_____ _____

Signature of Patient Date

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MEDICARE PATIENTS: SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made either to me or on my behalf to _Lamorinda ENT, Face & Neck Surgery_ for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print):

PROVIDER:

Sassan Falsafi, MD, MSChE

Patient's Medicare No.:

Date:

The patient is ultimately responsible for all professional fees.

I have read, understand and agree to the above policies regarding privacy and responsibility for payment of professional services.

_____ _____

Signature of Patient Date

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