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PATIENT FINANCIAL POLICY NOTIFICATION FORM

Dear Patient:

Dr. Sato is committed to providing you with the best possible care. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Multiple Bills: In addition to bills from Dr. Sato, you may receive separate bills for technical charges, such as medical equipment or supplies, procedures, etc. These items are billed by the individual suppliers and are separate from your physician services.

The following are the established financial policy guidelines that will be followed in resolving your charge balance:

1. Private Pay: Patient without insurance coverage must make payment in full before services are rendered.

Patient's Initials: _____

2. Commercial PPO/EPO: Any co-payments, deductibles, co-insurance, non-covered services, or amounts in excess of my policy's limitations, are due and payable at the time of service. Deductibles, co-insurance, and other amounts may not be known until after my insurance has considered the claim for payment. I understand that I will be billed for outstanding amounts as determined by my insurance. Outstanding account balances will be resolved within 30 days of billing.

Patient's Initials: _____

3. Point of Service (POS): I am electing to use optional Out-of-Network or Point-of-Service coverage for Dr. Sato's services. I acknowledge this choice will result in higher out of pocket expense for me. Outstanding account balances will be resolved within 30 days of billing.

Patient's Initials: _____

4. Medicare: Excluded services from the Medicare Program will be billed to me. For other services which may be denied, I will be asked to sign an Advance Beneficiary Notice and be provided with the estimated cost of the services should Medicare deny payment to the provider. I understand that Medicare requires an annual deductible and co-insurance that may not be covered by other insurance that I have and I may be billed for the balance. Outstanding account balances will be resolved within 30 days of billing.

Patient's Initials: _____

5. HMO: Any co-payments, non-covered or non-authorized services, or amounts in excess of policy's limitations, are due and payable at the time of service. Outstanding account balances will be resolved within 30 days of billing.

Patient's Initials: _____

6. State and Local Coverage: Any co-payments, deductibles, Share of Cost (SOC), excluded services, are due and payable at the time of service. Limited Scope Medi-Cal only covers specific types of

services; I will be billed for non-covered services. Outstanding account balances will be resolved within 30 days.

Patient's Initials: _____

Authorizations: Patients not confirming prior authorization and/or requesting service when authorization has been denied or has not been obtained will be billed as private pay account.

Collection Measures: Accounts not resolved within 90 days from billing may be referred to an outside agency for further follow up, reported to a credit reporting bureau, and may result in legal action. Please contact our billing office directly at the number on your bill to make payment arrangements.

Final Responsibility: Additionally and in any case, I understand that I am responsible for ensuring payment for services.

It is the patient's responsibility to notify office of any changes in insurance. Please notify the office as soon as possible to allow for authorization to be obtained and plan information to be updated.

Fees are as follows:

Returned check fee: $25.00 (Please note that once a check is returned to the office, we will not accept this as a form of payment in the future)

No show fee: $35.00

Late payment & collections fee: 20% of balance

My signature below acknowledges that I have been given a copy of this form and I understand my financial responsibility.

Patient name Patient Signature Date