Pulmonary and Sleep Associates of Marin

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PATIENT FINANCIAL RESPONSIBILITIES

Co-Payment and Deductible

You are responsible for your deductible and co-payment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Your co-payment is also due at the time of service.

Medicare

We accept Medicare assignment. You are responsible for your deductible and co-payment. If you have a secondary insurance carrier, a portion of your co-payment may be covered.

Non-Covered Services

You are responsible for payment in full for all services that we provide. As a courtesy, we will bill your health plan. However, you will be responsible for payment in full for any and all services including those not covered by your health plan. Your signature, below, constitutes agreement to pay for such services.

Appointment Cancellation Charge

A fee of $50 may be charged for appointments cancelled without a minimum of twenty-four hours notification.

Payment Arrangements

Payments may be made in cash, by check or credit card. We also offer payment plans.

Collections

If it is necessary to assign your account to a collection agency and/or attorney, you will be responsible for all of our collection agency and attorney fees and costs.

We are happy to discuss with you any questions relating to the information above. We thank you for choosing us for your medical care.

Telemedicine

Coverage of telehealth services varies. For example, Medicare coverage of telehealth is limited at this time. You are responsible for paying any amounts due for telemedicine services that are not covered by your insurer. Medicare beneficiaries will be asked to fill out an Advance Beneficiary Notice of Noncoverage Form ahead of time, if they wish to participate in Telehealth.

I understand and agree to all of the above, including that I am responsible for payment in full for all services rendered.

_____
Print Patient Name

_____ _____
Signature Date

If you are signing as a representative of the patient, please provide your name and your relationship to the patient:

_____ _____
Name Relationship