FINANCIAL POLICY:

The above physicians are all sub-specialists certified by the American Board of Internal Medicine in both Internal Medicine and Pulmonary Diseases. Dr. Mac Dannald, Dr. Kramer, Dr. Cheung and Dr. Zaka are Board Certified in Critical Care Medicine. Dr. Cohen, Dr. Cheung, Dr. MacDannald , Dr. Nachtwey and Dr. Zaka are Diplomates in the American Board of Sleep Medicine.

A consultation consists of history-taking, physical examination pertinent to your problems, and discussion regarding your problems. Time not actually spent with you consists of discussing your care with the referring physician, obtaining and reviewing your present x-rays and appropriate laboratory tests, discussing results and writing a report to your referring physician. The fee for a consultation or initial office visit ranges from $242 to $430. A follow up office visit ranges from $109to $254. Tests performed in our office (such as oximetry and spirometry) will incur additional charges.

MEDICARE PATIENTS:

We are participating physicians in the Medicare program and submit all billings to Medicare. You are responsible for your annual deductible as well as the 20% portion of the bill not covered by Medicare.

HMO/PPO PATIENTS:

HMO patients are responsible for obtaining an authorization from the primary care physician prior to each visit. We cannot see you without this authorization. If you elect to be seen without authorization, the charges will be your financial responsibility if your claim is denied. If you are a member of an HMO/PPO, you may be required by your health plan to pay a co-payment. We cannot waive the co-payment amount. All co-payments are due and payable at the time of the visit.

PRIVATE INSURANCE PATIENTS:

Your insurance is a contract between you and your insurance company. The fee for service rendered in this office is a separate contract between you and the physician. It is our policy to be paid at the time of the visit. For your convenience, we accept Mastercard, Visa, personal checks, money orders and cash.

CANCELLATIONS/NO SHOWS:

If you cancel an appointment with less than 48 business hour-notice, there is a $50 no-show fee. Failure to show up for an appointment will also result in a no-show fee. Repeat no-shows may be dismissed from the practice. Missed appointments create gaps in our schedule resulting in our inability to provide appropriate care to all patients.

CHARGES FOR COMPLETION OF FORMS, PHOTO COPYING OF MEDICAL RECORDS:

There is a charge for completion of forms and photo copying of medical records.

PAYMENT METHOD:

We accept cash, Mastercard and Visa. A $25 charge will be applied on all returned checks.

FINANCE CHARGE:

Any patient balance past 30 days will be assessed a service charge of 1.5% per month, as well as a $5/month handling fee.

NAME:_____ DATE:_____

I acknowledge I have read the above financial policy

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

Occasionally we are asked to provide your medical information to other treating medical providers and insurance companies involved in determining payments or benefits. We ask that you sign below to assist us in expediting those requests.

I hereby authorize Respiratory Medical Group, Inc. to furnish medical providers and insurance companies with any and all information they may request to further my medical care or process payments or benefits.

SIGNED _____ DATE _____

ASSIGNMENT OF BENEFITS:

I hereby assign medical and/or surgical payments to include major medical benefits to which I am entitled, private insurance and any other health plan to RESPIRATORY MEDICAL GROUP, INC. for services provided by the physicians at Respiratory Medical Group, Inc.

I understand that if claims are denied due to eligibility status, etc., I will assume full responsibility for all charges incurred by all dependents and me. I understand that I am financially responsible for any non-covered benefits, deductibles, or any co-payments for services that have been provided to me.

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.

SIGNED _____ DATE _____