OFFICE FINANCIAL POLICY AND SERVICE CONTRACT

PLEASE INITIAL BESIDE EACH NUMBER. THANK YOU

_____ 1. I understand that Warren J Reingold MD AMC will bill my insurance as a courtesy, but my patient portion (co-pays for office visits, deductible, and coinsurance for procedures) is my responsibility and due at the time of service. If your staff is unable to determine what my responsibility will be, I will be billed and my payment is due upon the receipt of the first invoice. An interest charge of 1.5% per month or 18% per year may also apply to delinquent balances. If your account is sent to an outside collection agency there will be a 30% fee added to your outstanding balance. This office policy is an effort to reduce costs related to our collection efforts so we can offer you more affordable healthcare overall.

_____ 2. I understand that if Warren J Reingold MD AMC is contracted with my insurance company, you will apply the contracted adjustment to my claims reducing my costs. If I have Medicare, you will file my secondary insurance. For both Medicare and other major insurances, I understand your staff will notify me of any services recommended for me that my insurance may not cover. I understand that these non-covered services that may be considered not medically necessary by my insurance are my responsibility and the contracted rate adjustment will not apply.

_____ 3. I authorize Warren J Reingold MD AMC to release any information to my insurance company, adjuster, or attorney involved in this case.

_____ 4. I have received a copy of the notice informing me of my privacy rights and understand that my health information will be used for treatment, billing, and office operation.

_____ 5. If my insurance fails to pay my claim in a timely manner, I authorize Warren J Reingold MD AMC to initiate a complaint to the insurance Commissioner for any reason on my behalf.

_____ 6. I authorize payment be made by my insurance company directly to Warren J Reingold MD AMC. If my current policy prohibits direct payment to Warren J Reingold MD AMC, I hereby instruct my insurance company to make out the check to me and mail it as follows 12139 Riverside Dr. Valley Village, CA 91607. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

_____7. I authorize Warren J Reingold MD AMC to deposit checks received on my account for services rendered if they are made out in my name.

_____8. My primary insurance company _____, is responsible for this bill. I may have a secondary benefits with another insurance company, but primary responsibility for my claim is with _____ insurance company. A photocopy of this financial agreement shall be considered as effective and valid as the original.

By signing below, I acknowledge that I've read and accept all terms of the above agreement. I also understand that I'm welcome and encouraged to express all concerns arising out of the financial aspects of my medical care.

_____ _____ _____

Patient Name (Printed) Signature Date