

Theresa M Cukierski, LLC
Financial Policy

Basic Policy

Payment in full is due at the time service is provided unless prior arrangements have been made. Co-payments are due at the time of service. If you are unprepared to pay your co-pay on the day of your visit a \$5.00 service fee may be charged to your account.

Clients with Insurance

Please contact your insurance prior to your appointment to verify your coverage.

I am an in network provider with Medical Mutual, Paramount, and FrontPath Health Coalition. If provided correct paperwork, I am able to bill your primary or secondary insurance. If your insurance requires a referral or prior authorization **it is your responsibility to assure that one is available to our office prior to or at the time of your service.**

Co-payments, coinsurance and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private contract between you and your carrier, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If you have questions about your benefits or your insurance carrier's decision to pay or deny your claim, please contact your insurance carrier directly. If an insurance carrier has not paid within 90 days of billing, professional fees are due and payable in full from you.

Non-covered 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.

Collection of Fees

With an overdue balance, I will make reasonable attempts of contacting you via postal mail and/or telephone to notify you of an overdue balance, a due date, and the credit card information held on file. If payment has not been rendered by due date, the active credit card held on file will be charged in full. Under most circumstances, I am willing to establish a payment plan. If the credit card on file is no longer active, and contact has not been made prior to the due date, your fees will be sent to a collection agency.

In the event action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees as determined and awarded by the court. If this is referred for collection, I/We agree to pay collection fees up to 25% on the balance owing. If legal action is deemed necessary, I/we agree to pay reasonable attorney's fees and court costs in addition to the above costs.

Signature on File and Assignment of Insurance Benefits

I have read, understand, and agree to the above financial policy for payment of professional fees and understand that I am ultimately responsible for payment of all professional fees.

I hereby assign all benefits for any services furnished to me to Theresa M Cukierski, LLC. 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.

Signature

Printed Name

Date