FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you the best possible care. If you have medical insurance to cover non-cosmetic medical care, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your cooperation and your understanding of our payment policy. We will gladly discuss your proposed treatment(s) and answer any questions relating to your insurance.

We will be happy to help you process your insurance claim. You must realize that:

1. Your insurance is a contract between you and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Tim Sayed MD, P.C. does not participate in many insurance plans. If your treatment is a covered benefit for a plan in which the practice is an enrolled in-network provider, we will work with your insurance company to file claims for the insurance company's portion of payment. However, you are still responsible for your portion including deductibles, co-pays, and co-insurance charges.
4. Our fees are based on the quality of the service provided and generally fall within the acceptable range for our geographic coverage area(s) by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 80%, or 120%) or "U.C.R." "U.C.R" is defined by your insurance company as Usual, Customary and Reasonable. This statement does not apply to companies which reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We do expect you to pay for all services and portions of services that your insurance carrier will not cover.

We do expect to be paid any balance exceeding 45 days of said professional service. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact us promptly for assistance in the management of your account. You can arrange to pay as little as $10.00 monthly to help avoid or limit collection attempts.

PATIENT PAYMENT RESPONSIBILITY

I have read the "Financial Arrangements and Medical Insurance" form above and I understand that all charges incurred are my responsibility whether my insurance company pays or not. I understand that I am responsible to meet my insurance deductible in addition to payment for any services or treatment not covered by my insurance carrier. This includes, but in not limited to, circumstances such as insurance denial of payment, out-of-network surcharges beyond the

maximum allowable out-of-network benefits, cosmetic fees, copays, co-insurances, and other categories of non-payment.

Tim Sayed MD, P.C. has offered to file necessary insurance forms with my primary carrier at no charge, for my convenience. I hereby agree that I will pay promptly to Tim Sayed MD, P.C. any amount outstanding on my account after insurance payments are collected, and all payments I may receive directly from any insurance carrier that are remitted for the services performed. I will immediately (no later than 5 days after receipt) pay over such payments to Tim Sayed MD, P.C. I understand that failure to do so is a breach of financial responsibility and may represent a fraudulent abuse of insurance coverage.

In the event that my insurance carrier refuses to make payments against my claim for services rendered by Tim Sayed MD, P.C., for any reason, I accept responsibility for prompt payment for any treatments and services I have received through Tim Sayed MD, P.C.

If, for any reason, an account balance is outstanding for six months, I understand that my account will be sent to collections. I understand that once my account has been turned over to collections, my account will be listed with credit bureaus and although no emergent medical need will be ignored, no follow-up visits, procedures or treatments will be rendered until my account is paid in full. I understand I will be discharged within 30 days of an account being deemed delinquent and collection efforts will continue until satisfied.

I understand that all returned checks are subject to an additional fee of $25 per check

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Patient Signature: _____
Name: _____

Relationship to Patient (If Patient is a minor or under guardianship): _____

Witness Signature: _____