Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment on your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

- We accept cash, checks, MasterCard, and Visa
- We offer an extended payment with prior approval
- Your co-payment is due at the time of service.
- All immunotherapy vials need to be paid for if they are to be taken out of the office.

Regarding Insurance

Whether your insurance pays or not, you are responsible for the balance. We do require your co-payment or co-insurance (10%, 20%, etc.) to be paid at the time of service. Please be aware of the requirements of your plan. We cannot bill your insurance unless you bring all of your insurance information. Your insurance policy is a contract between you and your insurance company; we are not a party to this contract. Please be aware that some, perhaps all of the services provided may be non-covered services and not considered reasonable and customary under the Medicare Program and/or other medical insurance.

Patients who wish to submit claims themselves must pay in full at the time of service, unless other arrangements are made.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our specialty. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Once balance becomes patient responsibility, the account must be paid in full within three (3) months to keep account out of collections. If your account must be turned over to a collection agency, you will be held responsible for all collection fees. In addition, you will be held responsible for any legal and court fees.

Our nurse practitioner may see you independently, but Anjuli S. Nayak, M.D, endorses all of his clinical decisions.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to the Financial Policy.

X_____ Date:_____

Signature of Patient or Responsible Party

X_____ Date:_____

Signature of Co-Responsible Party