

ANDREW L. SIMON, M.D., F.A. C.S.
459 Jack Martin Blvd #3
Brick, NJ 08724

FINANCIAL POLICY

We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company. Your doctor's bill for the services provided to you is an agreement between you and your Doctor. You are personally liable for all balances not covered by your insurance.

PAYMENT in full is expected at the time of service unless you are covered by an insurance carrier in which Dr. Simon is considered a participating provider. If we do participate with your Insurance Plan, we will submit all charges to your insurance carrier. You are responsible for deductibles, co-pays, non-covered services, coinsurance, items considered "non medically necessary" by your insurance company and other charges you may incur for services rendered by us. It is your responsibility to understand and comply with all the terms of your insurance contract including predetermination of benefits or referral requirements.

REFERRALS: Many insurances require a referral from your Primary Care Physician. It is the patient's responsibility to obtain the referral prior to the time of service. If a referral is not presented at the time of service, the patient will either be rescheduled or will be responsible for payment in full for that service at the time of service. All co-payment's must be paid at the time of service.

INSURANCE: As a courtesy, we will submit to your secondary insurance if it does not automatically cross over from your primary insurance. We **DO NOT** bill third insurance.

PAST DUE ACCOUNTS: An account is considered past due if payment is not received within the 30 day billing cycle. Interest may be added on balances over 60 days. If a delinquent account is sent to a collection agency, a \$50.00 fee will be added to the balance.

CO-PAYMENTS: Payment for co-pays is expected at the time of service. No exceptions.

RETURNED CHECKS: A \$25.00 fee will be charged for all checks that are returned for non-payment.

NOTIFICATION: For all issues concerning insurance and payment we will first contact you at the numbers you have provided to us on your enrollment forms. If you do not respond we will attempt to contact you through the emergency contact you have provided. You are responsible to notify us promptly of any changes to your address, phone number, insurance information or emergency contact.

RELEASE OF INFORMATION: I authorize Andrew L. Simon, M.D., F.A.C.S to release to my insurance carrier(s) and/or CMS (formally HCFA) and its agents and/or Medigap insurer any information needed to determine benefits or benefits payable for related services

ASSIGNMENT OF BENEFITS: If my insurance carrier is Medicare, I authorize benefits be made either to me or on my behalf to Andrew L. Simon, M.D., F.A.C.S. for services furnished me by that provider.

If my insurance is Medigap or a Commercial Insurance, I assign the benefits from my insurance carrier(s) to Andrew L. Simon, M.D., F.A.C.S. for the medical/surgical benefits I am entitled to.

We accept cash, checks, money orders, Visa and Mastercard.

I have read the Financial Policy, Assignment and Release of Information paragraphs stated above. I understand and agree to the above.

Print Name _____ Signature _____ Date _____

A COPY OF THIS NOTICE WILL BE FURNISHED UPON REQUEST