

BAY AREA HAND SURGERY ASSOCIATES
Mathias Masem, M.D.

PATIENT FINANCIAL POLICY

The following financial policy is effective as of January 1, 2006. All patients, new and returning, must sign and date this agreement prior to seeing their provider.

It is the patient's responsibility to provide this office with current, complete, and accurate insurance information. Any delay in providing accurate information may result in a denied claim. In the event of a denied claim, the patient will be held responsible for the entire bill. Immediately inform our office staff of any changes in your address, phone, or insurance coverage.

The patient is responsible for determining their coverage for office visits, special diagnostic testing, medical treatment and surgery. It is the patient's responsibility to:

- ? determine if a Bay Area Hand Surgery Associates physician is within their particular insurance plan network, HMO or PPO.
- ? determine if their insurance company requires a pre-authorization prior to scheduling an appointment.
- ? Obtain any required insurance company authorization PRIOR to any visit.

OUT OF NETWORK PRIVATE PATIENTS

If Bay Area Hand Surgery Associates physician is an out of network doctor for your plan, we will submit claims to your insurance company as a courtesy. However, we will not take any additional adjustments, as required under a PPO contract, and you will be responsible for all unpaid charges that are not covered by your plan. Should your account become overpaid, we will issue a refund check.

IN-NETWORK PRIVATE PATIENTS

Please be prepared to pay your co-pay at each visit. You may also be asked to make multiple co-pays to make your account current. We accept Visa and Mastercard. If Bay Area Hand Surgery Associates is a participating provider with your insurance plan we will bill your

insurance company for you. You will be responsible for any amounts deemed to be your responsibility by your insurance plan.

ALL INJURED PATIENTS

Any patient seeing a provider in this office as a result of either an industrial injury or a personal injury, i.e. a motor vehicle accident or slip/fall type injury, must provide this office with complete information. This includes accurate details of the injury: date, time, place, and how the injury occurred. Patients must respond to any inquiries from their insurance company in a timely fashion with regard to our medical claims.

Bay Area Hand Surgery Associates will not become involved in disputes between the patient and the insurance company regarding deductibles, co-payments, covered charges, etc.

OFFICE PAYMENT POLICY

Payment for office examination and treatment is required in advance of treatment unless other arrangements have been made with the office administrator. Our office can assist you in submitting insurance claims but this is not a substitute for payment for services rendered.

PATIENTS WITH INDUSTRIAL INJURIES

If you have a work-related injury and you have filed a claim, our office must have written prior authorization from your employer's workers compensation carrier to schedule an appointment for you. Please contact the Workers Compensation claims adjuster handling your case and request the necessary information be faxed to our office. Additionally, if your work-related injury has been accepted as a claim, be aware that we can not bill your private insurance. Private insurance companies will not cover medical expenses for an active industrial injury claim.

I have read and agree to the above financial policy.

Signed: _____ Date: _____

Printed Name: _____

PAYMENT POLICY

Payment for office examination and treatment is requested in advance unless other arrangements have been made with the office manager.

We are happy to assist you in submitting your insurance claims, but remember that insurance is a method of reimbursing you, the patient, for fees paid to the physician. It is not a substitute for payment.

Authorization for Release of Medical Information

I hereby authorize the release of any and all information acquired in the course of my examination and treatment for the purpose of securing payment of benefits from my insurance company. A photocopy of this agreement is to be considered as valid as the original.

Signature _____ Date _____

Assignment of Payments

I hereby assign all surgical and/or medical benefits for services rendered, to be paid directly to the Oakland Office of Dr. Mathias Masem, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature _____ Date _____

