

**MICHAEL E. BUXBAUM, D.O. P.A.**

**FINANCIAL POLICY**

**FINANCIAL RESPONSIBILITY**

It is the policy of MICHAEL E. BUXBAUM, D.O. P.A. to bill your insurance carrier as a courtesy to you, even though you may be considered responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days, the applicable balance will then be due in full from you. Unless your insurance company has a contract with MICHAEL E. BUXBAUM, D.O. P.A. to pay based on a specific negotiated fee schedule; you may be held responsible for any difference remaining between the insurance payment and the total charges.

We also require that arrangements for payments of your estimated share be made today. If any payment is subsequently made by your insurance carrier in the excess of the balance of your account, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to MICHAEL E. BUXBAUM, D.O. P.A.

However, if you are an HMO enrollee, the above statement only applies to your applicable co-pay and/or any other non-covered charge that you have agreed to be responsible for in advance of treatment. If you are a Workers' Compensation patient, you will only be held responsible for your charges in the event your claim is converted (not approved by either your employer or insurance company).

You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney by MICHAEL E. BUXBAUM, D.O. P.A., you will be responsible for all cost of collecting monies owed including court cost, collecting agency fees and attorney fees. You also understand that you are responsible for keeping MICHAEL E. BUXBAUM, D.O. P.A. advised of any address change. If any correspondence is returned, you understand that the account will be considered in default and will be turned over for collection immediately.

The above information has been read and your signature on this form signifies that you understand your responsibilities for the payment of your account.

**ASSIGNMENT OF BENEFITS**

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to MICHAEL E. BUXBAUM, D.O. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize MICHAEL E. BUXBAUM, D.O. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from MICHAEL E. BUXBAUM, D.O. P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date