MEDI CLINICS PRIMARY CARE LLC
DR VENKATA BIREDDY

Financial Responsibility Form

Medi Clinics Primary Care LLC strives to deliver the best possible care. In order to serve this purpose, it is important that you understand the process of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your individual responsibility.

INSURANCE COVERAGE: It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, exclusions and limitations, and authorization requirements. This information can be obtained by contacting your Insurance carrier. We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for any payments due will be yours. If you have had any changes in your insurance coverage, you must notify us immediately and provide a copy of your new insurance card.

CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES: Co-payments and coinsurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Please understand that you will be expected to pay your co-payment for each and every date of service. You are responsible for paying your deductibles. The deductible is determined by your individual contract with your insurance carrier. We may not have information about each person's deductible amount, or how much of it has been met. You will be responsible for finding out all information regarding your deductible prior to your appointment with our office. All deductibles start over at the beginning of a new calendar year.

SELF-PAY: All cash patients and patients present without valid insurance information are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel prior to your visit. Should you have insurance but are unable to provide valid information at the time of your visit, you will be expected to pay in full at time of service until your insurance information is on file.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you call our office and cancel your appointment within 24 hours of the scheduled visit or else you are subject to a no show fee of $25.00. This courtesy allows my office staff to schedule another patient who is also in need of medical care.

We will send a statement to your billing address notifying you of any balances due. Any unpaid balance is patient's responsibility and payment in full is due upon receipt of the statement. Payment not made within 30 days of the statement issue date is deemed past due. Past due accounts are subject to a $25.00 monthly late fee. Payments not received within 60 days of statement date will be sent to the collection agency and/or attorney. You will be responsible for all collection cost incurred, including attorney's and court fee, if applicable.

If you are unable to pay the balance due in full, you must contact our billing office to discuss possible payment options.If your account is assigned to a professional collection agency, you will no longer be able to receive services from our providers.Thereafter, any future services rendered will require that you pay upfront and in full at the time of service.

If your statement balance is paid by check and the check returned unpaid by your bank for any reason, a $50.00 returned check fee will be added to your account and the past due policy above will also be reactivated.

I understand and consent to above

Print name: _____

Signature: _____

Date: _____