# CREDIT POLICY

Patient Name _____ Date of birth _____

We are committed to providing the highest level of professional medical care and personal service. By selecting us, you have expressed confidence in our ability to meet this commitment. In turn, we feel it is the patient's/guardian's responsibility to meet his or her financial obligations.

As we see patients from many insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. It is your responsibility to insure that your insurance plan is in effect at the time of service and that all services rendered by our office on your behalf are paid in full within thirty (30) days of your statement date. In some instances, our office will not be able to bill your insurance carrier for you (e.g. in the case of motor vehicle accidents, workmen's compensation, immigration exams, and some international insurance plans). However, you will be provided will all the information necessary to submit a claim to your insurance company and you will be required to pay for these services in full at the time of service. Please inform us of any change of insurance carrier or personal information (name change, address, telephone number, employment).

It is important that you bring proof of insurance each time you visit our office. Failure to do so may result in your not being seen or your being required to make a full payment at the time of service. Please be aware that you are responsible for payment of your co-pay at the time of service. The patient's financial responsibility may include, in addition, co-insurance and deductibles and services not approved or paid for by your insurance carrier. This financial responsibility also applies if your insurance carrier is not contracted with Dr. Tatelman or if your insurance coverage is either terminated or not yet in effect. Our office accepts cash, check and major credit cards (Visa, Master Card and Discover). All returned checks will be assessed a $20 processing fee.

All appointments missed or cancelled with less than 24-hour notice will be assessed a $45 fee for an office visit, and a $75 fee for a physical. Certain forms which need to be filled out by the doctor will be charged for at the rate of $10-15 per page, and $45 for more complicated forms. In addition, copying of medical records will be assessed a fee of $10 for the first 10 pages, and 0.25/page thereafter.

AUTHORIZATION FOR RELEASE AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medi-Cal, Government and any other third-party benefits made on my behalf and/or on behalf of all members covered on my insurance plan be made directly to Joyce Tatelman, MD for services furnished by our office. I authorize the release of medical information about me needed to determined benefits. I permit a copy of this authorization to be used in place of the original. I permit a copy of this authorization to be sent to our billing office. Please feel free to contact our biller with any billing questions at 650 331-0058.

I have read and understand the policy stated above.

_____ (Signature) _____ (Date)