AARON S. BRANSKY, MD, PA

6309 PRESTON ROAD, SUITE 1200 PLANO, TEXAS 75024 ▪ 972-612-3965 ▪ FAX 972-618-4219

FINANCIAL POLICY & AGREEMENT

PATIENT NAME: LAST _____ FIRST _____ M.I. _____

This practice will provide medical services to all patients regardless of insurance coverage. This policy serves to assist you in understanding your financial obligations to this practice.

INSURANCE

This practice accepts all forms of insurance and works with all major insurance plans *except Medicaid*. However, this practice is not a contracted medical provider under any insurance programs except Medicare and Worker's Compensation. Therefore, we must emphasize that your policy is an agreement between you and your insurance company. All charges for our medical services remain strictly your responsibility from the date services are rendered.

A claim for all services performed by Dr. Bransky will be submitted to your insurance carrier whether or not we participate in your particular plan. All insurance companies have a schedule of fees (i.e. allowable, usual and customary, in network, etc.) specific to your particular plan based on which they will pay a claim in whole or in part. The fees charged by this practice may be more than what the insurance company provides. Therefore, any balance not covered by the insurance company, including but not limited to co-payments, deductibles, and co-insurance, remains the responsibility of the patient. We do not consider payment from your insurance company as payment in full.

UNINSURED AND MEDICAID PATIENTS

If you are uninsured or carry Medicaid insurance, our billing office will be happy to assist you with establishing a payment plan.

BILLING PROCESS

Patient statements are sent out every 30 days on or about the 15th of the month. If you are insured, your initial statement will be sent out upon receipt of a remittance notice and/or payment from your insurance carrier (typically 30-45 days from date of service).

PAYMENT FOR SERVICES PERFORMED

Unless a signed "Payment Plan and Agreement" has been established with our billing department, full payment is due within 30 days of the initial statement date. Any amount paid that is less than the full balance due will be considered partial payment whether or not it has been indicated as such on your statement.

Name on Card: _____ Circle Card Type: MC Visa Discover

Card Number: _____ Expiration: ___/____

Please note:

- All balances not paid within 30 days of the date of the initial patient statement may be charged interest of 1.39% per month and any courtesy discount extended may be forfeited.
- Checks returned by your bank are subject to a $25 processing fee.
- The undersigned irrevocably agrees that any unpaid balance remaining due after 90 days may be charged to the credit/debit card provided above.
- All accounts with balances 90 days past due, may be sent to a collection agency and eventually reported to the IRS as taxable income to you. Additionally, you shall be financially responsible for all collection costs and legal fees incurred in the collection of the unpaid balance.
- We will use any means you have provided and/or are available via public record, including but not limited to phone numbers, email addresses and networking sites for the purpose of contacting you regarding your account.

OTHER BILLS

Charges from our office are separate from those you may receive from the hospital, anesthesiologist, and/or other providers.

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and fully understand the financial policy set forth above and i agree to its terms and conditions.

_____ _____ _____

Patient or Legal Guardian Signature | Print Patient Name or Legal Guardian | Date