

Financial Policy

Cary S. Kaufman, M.D., F.A.C.S.

This is an agreement between Dr. Cary S. Kaufman and the Patient named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Cary S. Kaufman.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have insurance:

1. You provide all necessary and valid insurance information, we will bill your insurance for you and bill you for any remaining balances. You will pay all remaining balances you are billed for within 30 days of the first statement date.
2. You choose to pay your copay/deductible of \$_____ and any out-of-pocket portions at the time services are rendered by ___cash, ___check, or ___credit card.
3. You choose to pay all of your treatment by ___cash, ___check, or ___credit card. We will request your insurance carrier send their payment directly to you.

Payment options if you have no insurance:

1. You choose to pay in full by ___cash, ___check, or ___credit card on the day that treatment is rendered.
2. On treatment involving surgery fees you may choose to pay 50% on the preparation date and the balance in three weeks.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or nonpayment from the insurance company. In the case of reduced payment or nonpayment due to lack of referral you agree to pay all charges in full.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one (1%) percent per month or an **ANNUAL PERCENTAGE RATE** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned checks: There is a fee (currently \$25) for any checks returned by the bank.

Missed appointment fee: The second time a patients does not show up on time for an appointment, or cancels with less than 24 hours notice, a \$20 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

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Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Whatcom County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently \$25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Assignment of Benefits: I authorize my insurance benefits be paid to Cary S. Kaufman, M.D. (Bellingham Breast Center). I authorize the doctor and/or insurance company to release any information required for the processing and/or payment of my claims.

Patient's name: _____

Guarantor (if not the patient): _____

Signature: _____

Date: _____

Co-Signature: _____

Date: _____