



# OFFICE POLICIES

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

We provide you with the best possible care and service. We regard your understanding of our office and financial policies as an essential element of your care and treatment. Please read the following carefully. By signing this form, you attest that you have read and agree to our office policies. If you have questions about your account, charges, insurance or payments, please ask one of our representatives. Office hours are 9:00 am to 5:00 pm Monday through Friday. All routine phone calls to the office should be made during these hours. Messages left will be returned.

### Financial Policy

Your insurance plan may have copayments, co-insurance or deductibles for the plan that you choose. These fees are due at the time of service. We do not bill for these fees; they are due at time of service.

### Insurance Plans

If you are insured, we will bill those insurance carriers with which we have an agreement. However, it is ultimately your responsibility to become familiar with the details of your Insurance Plan, coverage and benefits. To find out what your insurance plan covers and what your financial obligation may be, we strongly recommend that you call the customer service department of your insurance carrier. The numbers are on your insurance card. Your deductible (an annual obligation) is due at the time of services if not met per insurance carrier. Most services are covered by insurance plans, in the event there is an exclusion in your plan we will bill the remaining balance to you. If your carrier determines the services are not covered, we will bill you and payment is due upon receipt of that statement. Any amount not paid by your insurance company within 30 days will be billed to you. If your insurance coverage is with a plan that we do not have an agreement with, payment is expected in full at the time of service. As a courtesy, we will submit a claim to that carrier on your behalf. You are responsible to notify us of your insurance, any changes to your insurance and to provide the necessary information about your insurance plan(s). Please have your current insurance card(s) with you for all visits.

### Medicare and Medical Advantage Plans

Terrance Kwiatkowski MD PC is a participating Medicare provider. Not all Medicare patients have traditional Medicare. If you have signed up with a Medicare Advantage Plan, it is your responsibility to verify if our physician is a participating Provider with your specific plan. MOST Medical Advantage Plans require a referral and or prior authorization from your primary care or health plan. If you have a Medicare Advantage Plan, you are responsible for obtaining prior authorization and/or referral for your initial visits and expired authorizations. We cannot see you without this referral or prior authorization according to your plan. Any amount not paid by your insurance plan within 30 days will be billed to you. If you have traditional Medicare we will collect the estimated co insurance amount at the time of service. If you have a Medicare Advantage Plan, we will collect your specialist co-pay at the time of services.

### Medicaid

Terrance Kwiatkowski, MD PC is a participating Medicaid provider for Nevada Medicaid. Not all patients have the traditional Medicaid plan. If you have signed up for a Medicaid HMO, it is your responsibility to verify if our doctors are participating with your specific plan. Most Medicaid HMO plans require prior authorization or referrals from your primary care provider or health plan. If you have Medicaid HMO, you are responsible for obtaining a referral or authorization prior to your initial visit. We are not able to see you without this important information.

### Delinquent Payments

Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Sinus Solutions has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (a) late fees and charges and interest due as a result of such delinquency; (b) all court costs and fees (but only to the extent allowed by law); and (c) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency.

### Self-pay Patients

If you do not have a current insurance plan to cover the cost of your treatment, you will be required to make full payment at the time of service.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date