DR DAVID J SILVERSTEIN ASSOCIATES
PATIENT FINANCIAL AGREEMENT

_____ _____

PATIENT NAME (PLEASE PRINT) **ACCOUNT # OR DATE OF BIRTH**

AS A PATIENT OF THIS PRACTICE, I UNDERSTAND AND AGREE THAT:

-Payment for medical services is expected at the time services are rendered. I may pay with cash, credit card (Visa, Master Card, Discover, American Express) or personal check. There is a $20 administrative fee added for all checks returned for insufficient funds or closed accounts.

-Our office participates with a number of health plans. If we participate with your carrier, we will file a claim on your behalf. We are not obligated to submit claims to carriers with whom we do not participate however, we may do so as a courtesy. Please be aware that we do not accept assignment on any claims submitted to a non-participating insurance carrier.

-All copays are due at the time of service as well as any balance due on your account. Certain medications and other products sold in this office, cannot be purchased unless your previous balance is paid in full. An administrative charge of $5.00 may be added for co-payments not received on date of service, and each billing cycle thereafter, until paid in full.

-If I cannot provide this office with proof of insurance, at time of service, you will be billed as a self-pay patient. Any changes to my insurance coverage, my name, address or telephone number needs to be communicated to our office staff upon check in or by phone. Please be prepared to present your insurance card at every visit. Any outstanding balances must be paid at time of service, unless payment arrangements have been made with our billing department. An additional $30 charge may be incurred for any balances sent to a collection agency.

-I am financially responsible for NON-COVERED services as determined by my health plan/insurance company. My physician or I may request procedures or treatments that are not covered by my insurance. It is my responsibility as a patient to understand my benefits and coverage of my insurance plan. I will contact my insurance for coverage questions.

-When a consultation, test or procedure is scheduled by the staff at our office it is ultimately your responsibility to contact your insurance company to verify that whichever service is being scheduled is a covered service and the specialist or facility you are being referred to is in-network. Our office is not responsible for any bills you may incur by having services performed at an out-of-network facility or by an out-of-network provider.

-I will be responsible for the payment of fees associated with the completion of FMLA papers, disability forms, work excuses, or employer paperwork and similar form completion.

Patient Name _____

Account # or Date of Birth _____

-If my insurance carrier requires a Primary Care Physician assignment, I am responsible for arranging this with my insurance carrier. I agree that Dr David J Silverstein Associates must be able to be confirmed on my insurance card, enrollment papers, or insurance eligibility list for my insurance to accept responsibility for services provided by my chosen PCP. If this is not confirmed, I have the option to reschedule my appointment or be seen and be responsible for payment of all services rendered on date of service. This pertains to commercial plans only.

-If you are a medical assistance patient, please be aware that as of this writing our office participates with UPMC for You, Amerihealth Caritas, Amerihealth VIP, UnitedHealthcare Dual and Gateway Medicare Assured. If our office is not listed as the primary care physician on the date of service, we will not see you as a patient, until it is confirmed that we are your PCP. It is your responsibility to contact your plan and make these changes.

-If I am a Medicare patient. I will be asked to sign waivers for any procedure or test that in the opinion of the physician. Medicare is likely to deny as unnecessary or non-covered. This may include tests and/ or routine medical exams. Medicare recipients are responsible for payment for Medicare waived services.

-I will be responsible for giving a 24-hour notice to cancel appointments for which I cannot show. I understand if I do not show, I will be charged a $35 fee. This fee is my personal responsibility and cannot be charged to my insurance. Repeated no-show patients may be released from the practice. Our answering service will not take cancellations, you must contact the office directly.

-I agree with my signature to all of the above. In addition, I allow Dr David J Silverstein Associates to bill my insurance and accept payment on my behalf. Also, to send billing and/or medical information to my insurance carrier for the purpose of processing claims.

Signature (parent/guardian if minor) _____

Date_____

Rev: 2/1/2020