Dr. Linda Kiley, Urogynecology & Advanced Pelvic Surgery, LLC
Financial Policy

Payment may be with: Cash, Check, VISA, MasterCard, AMEX, and Care Credit.

Payment **in full** is expected at the time of service. All applicable co-pays, deductibles and co-insurance will be collected at the time of service. We will accept payment for your treatment directly from your insurance company for the amount they state they will cover.

Fees not covered by insurance are your responsibility. If you are using your medical insurance, you must present your card **prior** to being seen.

You may **not** pay with cash or credit card, and then expect us to file to your medical insurance at a later time.

YOUR OFFICE CO-PAY MUST BE PAID IN FULL BEFORE YOU ARE SEEN.

A parent who brings a minor child to our office for medical care is legally responsible for payment of all of her charges.

An administration fee of **$25** is charged for all forms: Disability, FLMA, etc. This fee is due at time of request. Forms will **not** be completed without payment.

Even though you may have medical insurance coverage, **you** are ultimately responsible for payment of your account. Insurance arrangements are between you (the insured) and your insurance company.

This office makes **no** guarantee of benefits. Any quote of benefits provided by your insurance company is considered a general overview, and only a **guideline** until payment is finally received. All benefits are subject to review when the insurance company receives the actual claim form.

AUTHORIZATION FOR TREATMENT AND SERVICE, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND CHARGE TO MY CREDIT OR DEBIT CARD

I hereby authorize medical treatment for myself (or, my dependent) as deemed necessary by **Linda Kiley MD**, or **Joyce Defrancesco ARNP "MD & ARNP".**

I authorize **Linda Kiley MD** or **Joyce Defrancesco ARNP** and their designated employees to furnish information to my insurance company and other medical professionals regarding treatment or services provided to me (or my dependent), and regarding my medical condition or that of my dependent.

I hereby assign to Dr. Linda Kiley, Urogynecology & Advanced Pelvic Surgery, LLC any and all payments made for medical treatment or services provided to me or my dependent.

I understand and agree that I am ultimately responsible for payment of ALL charges rendered by Linda Kiley MD and Joyce Defrancesco ARNP for such medical treatment or services whether or not such charges are covered and paid (either fully or partially) by my insurance company.

**** OFFICE CREDIT/DEBIT CARD POLICY****

I understand it is the policy of Dr. Linda Kiley, Urogynecology & Advanced Pelvic Surgery, LLC to secure an imprint of my credit or debit card at the time of my visit.

If, after a claim has been submitted to my insurance carrier:

(1) The claim is denied as a non-covered service; **OR**,
(2) The charges are not paid (**or** only partially paid) by my insurance carrier.

MD & ARNP has my permission to charge my credit card or debit card for the **entire amount** owed for treatment and/or services provided to me or my dependent.

I understand that in the event my credit card has been charged for medical treatment or services, and then my insurance carrier subsequently makes payment to MD's for those charges, the office will issue a **credit** to my credit or debit card in the amount received from my insurance carrier.

Card: Credit / Debit (Circle One) **Visa / MasterCard / AMEX/ Care Credit (Circle One)**

Card Number: _____
Expiration Date: _____ CVV #_____
Name of Card Holder: _____
Signature of Card Holder: _____
Name of Patient: _____
Address: _____

I hereby authorize MD & ARNP and designated employees to charge my credit or debit card the full amount of all charges made for medical treatment and services provided by MD & ARNP and the amount charged to my credit or debit card will be reflected on my credit or debit card statement. The charge will be based on the medical treatment rendered to me (or my dependent) and the usual and customary charges made by MD & ARNP for such treatment and service.

If payment is denied by my credit or debit card company, I will pay the entire amount within 30 (thirty) days.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by MD or ARNP, and agree that if the office places my account with an agency or attorney for collection, MD & ARNP shall be paid by me for **all** of its costs and expenses in collecting monies owed to them to the extent allowed by applicable law. Those expenses include, but shall not be limited to, attorney's fees, court costs and other expenses incurred with collection of my account by an agency or attorney.

This authorization shall remain effective unless expressly revoked by me **in writing** and delivered to the office of Dr. Linda Kiley.

_____
Signature of patient/ responsible party

_____
Printed Name

_____
Date