

ABOUT FINANCIAL ARRANGEMENTS AND HEALTH INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for your portion of the services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, or VISA. We will bill your insurance company if you have provided us with your complete insurance information. **If you fail to provide the correct insurance information and the claim is denied for timely filing, you will be responsible for the charges.**

If you have contracted health care (such as an HMO or PPO), your payment policy may vary depending on the contract agreement. We are participating providers with Medicare and will work with Medicare patients on payment arrangements.

Please realize that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract unless you have HMO/PPO contract.
2. Not all services are a covered benefit on all contracts.
3. We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.
4. We ask that you take responsibility for your bill regardless of your insurance coverage.

Charges and arrangements for payment for surgery and obstetrical care will be covered in detail when those services are needed.

We will gladly discuss your proposed treatment and answer any questions regarding your insurance. Should temporary financial problems arise, please contact us promptly for assistance in the management of your account.

I authorize the release of any medical information necessary to process insurance claims for medical services rendered or to another physician or medical facility as may be necessary to my care. I authorize payment of medical benefits, including any Medicare/Champus benefits to Dr. Thomas R. Traylor, P.C., **I ALSO AGREE TO PAY IN FULL ALL CHARGES INCURRED IN MY CARE WITHIN 60 DAYS FOLLOWING SERVICE.**

I further agree, in the event this account is considered delinquent, to bear these additional costs: Collection fees and/or reasonable attorney fees of no less than 1/3 the balance due the provider.

I have read and agree to these terms and certify the above information is correct:

Signed: _____ **Date:** _____