

MARWAN M. SHAYKH, M.D.

**OFFICE POLICY REGARDING FINANCIAL ARRANGEMENTS AND
PATIENT RESPONSIBILITIES**

We are committed to providing you with the best care possible. In order to achieve these goals, we need your assistance and your understanding of our office policies.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is due at the time services are rendered, unless alternative payment arrangements have been approved in advance by our staff. This includes applicable coinsurance and co-payments for participating insurance companies. This policy is in accordance with legal requirements for collecting patient responsibility amounts. We accept cash, checks and all major credit cards. There is a \$25 service charge for returned checks.

Patients with an outstanding balance greater than 30 days past-due must make arrangements for payment prior to scheduling appointments. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$100.00. Please help us serve you better by keeping scheduled appointments.

INSURANCE

As a courtesy to our patients, our office makes every reasonable effort to obtain payment according to your coverage. We will accept assignment for those companies which we are contracted with. However, please understand that as a medical provider, our relationship is with you, not your insurance company.

Regardless of your insurance coverage, you are ultimately responsible for any charges incurred.

If you have any questions and are in need of assistance regarding the above information, please do not hesitate to ask our office staff. We are here to help you.

AUTHORIZATION

I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company. I authorize my insurance company, attorney or other parties to pay directly to Dr. Marwan M. Shaykh, MD and/or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collecting the account, including attorney fees.

I understand that not all services are covered by my insurance company, and that it is my responsibility to obtain benefit information for services that I receive.

Patient's Signature _____ **Date:** _____