

LASSEN MEDICAL GROUP
Financial Policy

We at Lassen Medical Group are committed to providing the highest level of professional medical care and personal service. For every commitment there is an obligation, at Lassen Medical Group, we are committed to providing quality medical care and service. Conversely, we feel it is the guardian/patient's responsibility to meet their financial obligation.

As we see patients from many insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. While it is our intention to assist you, it is still your responsibility to insure that all services rendered by Lassen Medical on your behalf are paid in full. In most instances, Lassen Medical will bill your insurance carrier for you.

For patients whose insurance is provided by a plan with whom we contract, we will submit the insurance claim, but we expect same day payment of all co-payments, deductibles and non-covered services.

We will bill all non-contracted insurance plans as a courtesy to our patients. However, we expect full payment at the time of service. Claims will be submitted and the patient is responsible for the balance billed.

It is important that you bring proof of insurance each time you visit the Clinic. Failure to do so may result in your not being seen or your being required to make a full payment at the time services are rendered. Lassen Medical Group accepts cash, check or major credit cards.

Proof of eligibility for Medicare, MediCal, contracted insurance companies and Worker's compensation cases is the responsibility of the patient. If the insurance carrier reports the patient is not eligible, the patient is responsible for full payment of charges even if litigation is pending,

Every effort will be made to bill your insurance company for physician services while in the hospital. If information provided is incomplete or erroneous, the patient is responsible for full payment or must provide the Business Office with corrected information.

Please make every effort to let us know if your insurance (primary or secondary insurance) carrier or your personal information (home address, employer, phone number) has changed since your last visit.

We understand that insurance coverage is very confusing to many people, and we are committed to helping you with any questions you may have. Please feel free to call the finance department at 527-0436.

I have read and understand the policy stated above.

Account Guarantor/Responsible Party's Signature

Date

AUTHORIZATION FOR RELEASE AND ASSIGNMENT OF BENEFITS

Release of Benefits and Information: I authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim.

I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Insured/Guardian

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date