

BRUCE E. WEST, M.D., P.C.

Financial Policy

Thank you for choosing **BRUCE E. WEST, M.D., P.C.** as your health care provider. We are committed to your successful treatment. In order to comply with Centers for Medicare and Medicaid guidelines (formerly Healthcare Financing and Administration), the Health Insurance Portability and Accountability Act (HIPAA) and Michigan State Regulations, the following is a statement of our Financial Policy.

Dr. West participates with most major insurance companies. As such, we are required to verify health insurance coverage each visit. Having your current and accurate insurance information allows us to process your insurance claim promptly and correctly. Many insurance companies have fixed allowances or percentages based on your contract with them. We are not a party to that contract. Therefore any disputes between you and your insurance company will not affect your obligation to pay your bill.

1. It is your responsibility to pay the deductible, co-insurance and other balances not covered by your insurance plan on the day service is rendered. Please be aware some of the services provided to you may not be considered reasonable and necessary under the Medicare Program, Medicaid and other medical insurance guidelines. You will be responsible for these balances.
2. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
3. We will assist you in receiving reimbursement from your insurance company where we are a participating provider, but you are responsible for your bill. You are also responsible for knowing your insurance policy and plan.
4. The adult accompanying a minor to our office and the parents (or guardians) are responsible for full payment.
5. You must obtain any necessary prior authorizations and/or referrals required by your insurance company prior to scheduling an appointment.
6. Any balance outstanding for more than 90 days will be sent to an outside collection agency.
7. A charge of \$35 will be assessed for each returned check to cover the corresponding bank charge and related costs.
8. A charge of \$25 will be assessed for a missed appointment.
9. For your convenience, we accept cash, personal checks, Visa or MasterCard.

If you have any questions regarding our Financial Policy, please contact the office billing clerk at (248) 352-8970 **prior** to signing this form.

I have read, understand and agree to comply with this Financial Policy.

Printed Name

Patient Signature (or person responsible for the account)

Date

Lahser Medical Campus
27177 Lahser, Suite 100
Southfield, MI 48034

Phone: (248) 352-8970
Fax: (248) 352-8933
Ans. Service: (313) 396-0578