FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

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

Payment for services are due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express and Discover. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

There will be a $25.00 charge of 5% of the check amount, which ever is greater, added to your account balance for checks returned unpaid by your bank. In addition, interest will be accrued for balances over 30 days at 18% per annum and a 35% collection fee added to account balances over 60 days.

Charges may also be assessed to your account for missed appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 805) of "U.C.R." "U.C.R." is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the Office Manager promptly for assistance in the management of your account.

For our HMO patients: **Your insurance carrier requires you to have a referral for every visit to Dr. Halfon. (Some do allow one well woman check up per year without a referral). It is your responsibility to obtain your referral prior to your visit with Dr. Halfon. If you do not have your referral, your visit will have to be rescheduled (delaying your treatment and care).**

If your have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

ASSIGNMENT OF BENEFITS

I hereby instruct and direct ______________________ Insurance Company to pay by check made out and mailed to:

Isaac Halfon MD FACOG 1447 Medical Park Blvd. #401, Wellington, FL 33414

Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Isaac Halfon MD FACOG1447 Medical Park Blvd. #401, Wellington, FL 33414

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said Professional service charges over and above this insurance payment.

- A photocopy of this assignment shall be considered as effective and valid as the original.
- I authorize Isaac Halfon M.D., to deposit checks received on my account.
- I also authorize the release of any information pertinent to my case to any insurance company adjuster, or attorney involved in this case.
- I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at ____________________ **Florida, this** _______ **Day of** ___________________ **20** ______

____ ________________________________

Signature of Policy Holder **Witness**

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Signature of Claimant if other than Policy Holder

If appointments are NOT canceled in advance, then a $25.00 charge will applied to your account.

Any balance not paid within 30days will accrue interest of 1.3% monthly on all unpaid balances.

I understand and accept both of the above policies.

Signature _________________________________