



Thank you for choosing MyDoctor LLC as your health care provider. We are committed to providing quality medical care. In an effort to avoid confusion and misunderstanding, we have adopted the following Financial Policy and require you to read and sign it prior to the commencement of any treatment.

**Insurance – all patients**

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy to you, we will file claims for those plans with which we have an agreement. If problems arise regarding coverage issues, we will work with you and your insurance company to help resolve them. *However, please be advised that you are nevertheless ultimately financially responsible for payment of medical services rendered by this clinic.* All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. This office is not responsible for disputing insurance company decisions regarding coverage, nor are we responsible for determining what services are covered and what services are not. Payment is due upon receipt of a statement from our office. We expect that you know your insurance benefits including, but not limited to: deductible and copayment amounts as well as labs, radiology facilities and hospitals contracted with your plan. It is your responsibility to notify our office when your insurance plan or benefits change. Any costs incurred by this office because of incorrect information provided to us by you will be your responsibility.

MyDoctor LLC does not bill any third-party insurers. If you received services that are payable by a third-party insurer, you will be charged the appropriate amount from our standard fee schedule, and are responsible for payment at the time of service.

**Non-insured concierge member patients**

Patients who are concierge members with MyDoctor LLC who do not have insurance or are insured with a non-contracted insurance plan will be charged a fee for services from our concierge cash patient fee schedule. Insured concierge patients who receive services that are deemed "not covered" by their insurance plan, will not be balanced billed for that service, limited to one (1) office visit per month, and one (1) well exam per year. Adult immunizations are excluded, and will be billed to you from the concierge cash patient fee schedule. Any additional non-covered visits will be charged to you from the concierge cash patient fee schedule. All deductibles, coinsurance, and co-pays are still applicable and must be paid in full as they are incurred.

**Non-insured non-member patients**

If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We will, as a convenience to you, provide a prepared claim form to allow the patient to submit for reimbursement if desired. We offer a competitive cash fee schedule for our patients with no insurance.

**Deductibles/Co-pays**

Our insurance contracts require us to collect deductibles and co-pays at the time of service.

**Appointments**

We strive to provide the best possible service and availability to all of our patients. Our policy is to charge for missed appointments unless cancelled at least 24 hours in advance. Our no-show/late cancellation charge is \$25. Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

**Paperwork Services**

Any paperwork filled out by our providers such as Short-term disability, or FMLA are subject to a \$25 charge

**Medical Record Copies**

Copies of medical records for personal use or for parties other than your insurance company or other physicians involved with your care are subject to a \$25 charge.

**Returned Checks**

All checks returned from the bank for non-payment are subject to a \$25 charge.

**Collection Agency**

Any account turned over to a collection agency are subject to a fee amounting to 30% of the total amount turned over.

**This financial policy supersedes all prior written financial policies, contracts, or verbal agreements.**

Patient Name

Date

10229 N. 92<sup>nd</sup> Street, Suite I-103, Scottsdale, AZ 85258  
Tel: (480) 455-3000  
Toll Free: (877) 818-6300  
Fax: (888) 203-2153

**Assignment of Benefits:**

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO MYDOCTOR LLC FOR ANY SERVICES FURNISHED ME BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES, FORMERLY KNOWN AS HCFA) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. *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 non-covered services.* Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

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**Patient Name**

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**Date**

Last updated July 10, 2009