FINANCIAL POLICY

We find that communication with our patients concerning our financial practices assist us in providing the best possible care. Therefore, we have taken this opportunity to inform you of the financial policies of Patrick J. Piovesan, D.M.D., P.C.

Our office fees are comparable to the usual and customary fees for our demographic area. You are responsible for payment of all non-covered services regardless of any determination of usual and customary rates made by your insurance company, with the exception of those programs in which we are a participating provider.

Payment in full is expected at the time services are rendered. This policy applies to co-payments, co-insurances, deductibles and non-covered services. This policy includes all co-payments for Concordia Plus patients.

It is your responsibility to obtain a prior authorization or referral from you primary care physician or dentist for office visits, diagnostic radiographs and other services related to each visit. If you do not have prior approval or a referral, you are responsible for payment in full the day services are rendered.

For non-participating insurance carriers, your insurance policy in a contract between you and the insurance company. As a professional courtesy we agree to submit claims to your insurance company. If your insurance company fails to pay within a 45 day period you will be expected to pay any outstanding balance in full. You must then collect from your insurance company. Also, payment is expected within 10 days for any insurance payment sent directly to the subscriber.

If your eligibility or coverage changes, please notify out office immediately.

For those patients that require extensive treatment and/or meet certain financial criteria, Patrick J. Piovesan D.M.D., P.C. provides payment plan programs. If this situation applies to you, please let us know.

Thank you for taking the time to read our financial policy. If you have any further questions, please ask to speak with someone in the billing department.

I have read and understand the financial policy of this office. (please sign below).

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I herby authorize Patrick J. Piovesan D.M.D., P.C. to release medical information to physicians, hospitals, sponsoring and/or compensating agencies and their agents/designees.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I herby authorize payment directly to Patrick J. Piovesan D.M.D., P.C. for services furnished to me. I understand that I am financially responsible to the facility for charges not covered by this authorization.

MEDICARE AUTHORIZATION TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER, PHYSICAINS, AND PATIENT:

1. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit the claim to Medicare for payment to me.

2. For outpatient services and/or equipment, I request that this authorization apply to the period of _____ to _____.

_____ _____

SIGNATURE DATE