

## Cesar A. Sierra, M.D.

### YOUR SIGNATURE IS REQUIRED AS PROOF OF READING THIS DISCLOSURE

Thank you for choosing Dr. Cesar A. Sierra as your Oculoplastic surgeon. We are committed to providing you with the best possible care. Due to the increasingly stringent rules and regulations of insurance companies, we ask that you read and sign the following prior to seeing the doctor. The following is a statement of our Financial Policy which is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Each patient is required to read and sign prior to any treatment.

#### INSURANCE

Your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. Our relationship is with **YOU**, not your insurance company. It is **YOUR** responsibility to be familiar with the rules and regulations of your insurance plan.

If you have insurance coverage with one of the plans in which we participate, we will bill your insurance company. However, all copays must be paid **at the time of service**. If the copay is not paid when services are rendered, you will be charged an additional **\$5.00 service fee**. If you have insurance in which we do not participate, we ask that payment be made in full after you are seen by the doctor. As a courtesy, we will give you the claim form that you should submit to your insurance for possible reimbursement.

Medicare and Medicaid (Medicaid secondary to Medicare) we require a payment of **\$25.00 each time you are seen in the office**. If you are scheduled to have surgery, we require a payment of **\$50.00 prior to scheduling your surgery**. Each payment will be applied to your account, but may or may not cover the cost of your visit(s) in full. You will receive a statement in the mail if you have a balance after Medicare makes a payment on your behalf.

Some insurance carriers require a **referral** from the primary care physician to see a specialist such as Dr. Cesar A. Sierra, M.D. If a referral is required to see a specialist **YOU** must contact your primary care physician well in advance to allow enough time for them to issue you the referral. **We will not contact your primary care physician for you!** Should you elect to waive the rules of your insurance plan by not providing the proper referral, you are accepting full responsibility for all charges incurred for all dates of services provided to you. Please note that referrals have an expiration date and/or limit on number of visits allowed. It is your responsibility to keep referrals up to date.

**You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information or are unable to verify your coverage, you will be required to pay for the services rendered to you that day.** It is your responsibility to keep our office updated on any changes in your insurance. If you have more than one insurance, please notify us of which is primary and which is secondary. Should your insurance terminate during your treatment, you will be responsible for payment of visits during insurance non-eligibility.

**Payments Due:** Patient Payment obligations are due, in full, at the time of service, unless you have made payment arrangements in advance with our billing department. Returned checks will be subject to an additional **\$30.00 service charge**.

Each month, you will receive a statement of services which, by law, is due and payable within **30 days** services rendered. If you are experiencing circumstances beyond your control, please call our office and we will be happy to make special arrangements.

**\*\*\*\*\*After 90 days, unpaid accounts will be placed with our collection's attorney, and the patient is responsible for any fees and costs associated with collecting the bill.\*\*\*\*\***

**Workman's Comp/Auto Insurance:**

If you are injured and an outside party is responsible for payment, you are required to supply the office with written documentation supporting coverage. **WE WILL NOT OBTAIN THIS INFORMATION FOR YOU.** The information must be received by our office within at least 48 hours prior to seeing Dr. Sierra. Such documentation typically includes but is not limited to; case number, responsible party name, address and telephone, date of loss, injury, etc. The office will verify this coverage prior to your appointment. If we are unable to verify coverage, you will become responsible for payment or will need to reschedule your appointment.

**Minor Patients:**

The parent or guardian who presents the child for medical treatment is the responsible party.

**Missed Appointments:**

Please help us serve you better by keeping scheduled appointments. If you must cancel or reschedule an appointment, please contact our office as soon as possible. **No shows will be charged at the rate of \$50.00.**

**Insurance/Patient Billing:**

Our office makes every effort to post payments from both insurance and patients when received. Occasionally, a delay may occur from the time you make a payment to the time it is posted to your account. If you receive a statement that does not reflect your payment, payment from your insurance, or indicates that your payment is past due, please feel free to contact the billing company located at the top of your statement.

Thank you for understanding our Financial Policy. Our practice firmly believes that good patient relationships are based upon understanding and open communication. Please do not hesitate to talk to our billing staff so that we can make every effort available to clarify any misunderstanding you may have concerning your balance or to answer any questions you may have concerning our practice's Financial Policy. We are here to assist you.

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Patient Name

Date

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Patient (Guardian) Signature