Kent Pulmonary
ASSOCIATES

KENT PULMONARY ASSOCIATES

Our Financial Policy

Thank you for choosing us as your pulmonary physician. We are committed to providing you with a consistently high standard of care and pleased to discuss our services at any time. Your clear understanding of our Financial Policy is an important part of our professional relationship. We request that you take time to review it and then sign it prior to receiving treatment from us. If you have any questions about our fees, financial policy or your responsibility, please ask to speak with our Practice Manager.

Our practice is committed to providing the best care for our patients and our fees are considered usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "usual and customary rates."

Co-pays are due and expected at the time of service. You may make your payment by cash, check, visa debit, or most major credit cards. It is our policy to charge a fee of $35 for any returned check. We participate with the Delaware Attorney General's Office CHECK ENFORCEMENT PROGRAM, which will take legal actions against bad check writers.

Your insurance coverage is a contract between you and your insurance company. We will file an insurance claim as a courtesy to our patients; however, this does not release you of your financial responsibility. If your insurance company has not paid your account within sixty days from the time of service, the outstanding balance automatically becomes your responsibility. We will not be involved with the disputes between you and your insurance company regarding deductibles, co-pays, covered charges, etc., other than to supply factual information as necessary. Please be advised that some and perhaps, all of the services provided to you may be considered a non-covered service or medically unnecessary by your insurance. In this case, you will be financially responsible for the timely payment of your account. For those who request it, we provide an estimate of the cost of the service to be performed, if such information is available to us.

As a patient, it is your responsibility to advise us if you have a change in your demographic information. In compliance with federal regulations we require you to provide us with a proof that would reflect the demographic change. We also require you to present a valid insurance identification card and are mandated by federal regulations to ask for photo identification card, preferably a state driver's license at each time of visit. Furthermore, we asked that you call 24 hours prior in case you need to cancel your appointment and any minor patient must be accompanied by an adult representative who has assumed financial responsibility for the minor patient. Patients who require their insurance to have a referral/ authorization from their Primary Care Physician must be responsible in obtaining them prior to seeing us. Denial of insurance due to this reason will result to patient responsibility of the balance.

Please be aware that you may set up a payment plan at any time with our billing company. We reserve the right to take lawful actions including terminating our physician-patient relationship for non-payment.

Telemedicine Consent and Disclosure:

I consent to Telemedicine and Remote Monitoring Services provided by all Providers at Kent Pulmonary Associates. I understand that my insurance will be billed for all reimbursable expenses and that I will be responsible for all co-payments, coinsurances and deductibles. If I am a self-pay patient, I will be responsible for all services rendered, according to the office's self-pay fee schedule.

Thank you for taking time to review our financial policy. Please let us know if you have any questions or concerns.

Date: _____

Printed Name of Patient: _____

Patient's Signature: _____