Multiple Sclerosis Center of California

Daniel S. Bandari, M.D, Inc.

OUR FINANCIAL POLICY

Thank you for choosing MS Center of California and Daniel S. Bandari, MD as your health care provider. Please understand that payment of your bill is considered a part of our mutual relationship and your responsibility. The following is a statement of our financial Policy, which we ask that you read and sign prior to your evaluation, consultations or recommendations of treatments.

WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, DISCOVER, AND AMERICAN EXPRESS.

WITH PRIOR CREDIT APPROVAL, WE CAN ARRANGE A PAYMENT PLAN.

1. As a courtesy to our patients, we will accept assignment of benefits; however, we do require payment of any uncovered portion, such as deductibles and co-payment to be paid at the time of service.

2. If your insurance is inactive at the time of service, you will be considered a cash (self) pay patient. You agree that your insurance shall not be billed a claim for the date of service in question. This includes all billing performed by the physician's office or submitted directly to an insurance company by the undersigned or your representative.

3. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. For visits that we have billed, if your insurance company has not paid your account in full within 90 days, any unpaid balance will be due in full. Medical bills fall under the Fair Debt Collection Practices Act because medical debt meets the definition of a "debt" under rule 803(5). (Excerpt from Fair-Debt-Collection.com).

4. For visits that we bill, we cannot bill your insurance unless you provide all the correct insurance information.

5. Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge arbitrary determination of usual and customary rates.

6. Account balance over 90 days will be charged a service charge of 18%

7. If you are a member of a Managed Care Insurance HMO or PPO, it is your responsibility to know your type of insurance (HMO or PPO or etc.), policy provisions and to inform this office of them and also inform us if your plan changes.

8. OUT OF NETWORK PLANS. In cases when we are NOT providers for your insurance, your visit will be an Out-of-Network service which you will be personally responsible for. We WILL NOT bill to any Out-Of-Network health plan unless otherwise specified by this office or our billing office. Your insurance may impose a deductible and higher co-payments than if you received services from a provider in your network. If you do not have Out-Of-Network benefits, you are personally responsible for the full amount of the charge payable upon demand.

Initials: ______________________

MULTIPLE SCLEROSIS. NEURO-IMMUNOLOGY. DEMYELINATING DISEASES OF BRAIN & SPINAL CORD

3900 WEST COAST HIGHWAY, SUITE 330, NEWPORT BEACH, CA 92663. TEL: 949-706-5580, FAX: 949-706-5585

Financial Responsibilities:

1. Financial arrangements are available to our patients but only with the discretion of this office and must be made in a timely manner. Such financial agreements are a commitment to pay on time at a frequency previously discussed.

Initials: ______________________

2. The patient is financially responsible for ALL co-payments, co-insurances, deductibles, and any limitations and or exclusions to their plan.

Initials: _______________________

3. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $75.00 for new appointments and $50.00 for follow up visits. This will be due upon demand.

Initials: _______________________

BY SIGNING BELOW I (PRINT NAME)____ACKNOWLEDGE THAT I HAVE READ THE FINANCIAL POLICY IN ITS ENTIRETY AND COMPLETELY UNDERSTAND AND AGREE WITH ITS CONTENTS AND POLICIES IN ITS ENTIERITY. I ALSO UNDERSTAND THAT THESE POLICIES MAY BE CHANGED OR MODIFIED IN WHICH TIME I WILL BE PROVIDED WITH PRIOR NOTICES.

Signature of patient/responsible party ____ Date: ___________________

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