BASSI CLINIC
YOUR HEALTH.OUR PRIORITY

11110 N Tatum Blvd., Ste 103, Phoenix, AZ 85028
Phone: 602.354.3311 • Fax: 602.354.3751

FINANCIAL POLICY

YOU WILL BE REQUIRED TO SIGN A NEW FINANCIAL AGREEMENT EVERY 12 MONTHS.

Patient Name: _____ Date of Birth: _____ Date: _____

Thank you for choosing Bassi Clinic. We are committed to providing the finest personalized care. Please carefully read and sign the following statement of our office policies prior to your treatment. Feel free to speak to our office if you have any questions.

INSURANCE:
You are ultimately responsible for payment of services if your insurance carrier does not pay for any reason. **IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE**. Please present your insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. Current policies in the “ACA” Affordable Care Act may delay payment of your claims due to non-payment of policy premiums by the patient. If your insurance delays, denies or pays and then re-coups the payment of your claims due to non-payment of the policy premium, you will be responsible to pay the claim in full in accordance with our “Financial Policy” guidelines.

The patient is responsible for obtaining all necessary information regarding referrals or authorizations to another physician. Failure to do so may result in denial or delay of payments. Please allow five days for the office to obtain your referral.

NO SHOW/LATE CANCELLATION FEE:
If you need to cancel your appointment, please contact our office **at least 24 hours before** your appointment time. Because of the high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. A **$50.00 fee** will be assessed for all missed appointments not canceled with **at least 24 hour** advance notice.

BILLING:
As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification and your insurance card. Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.

In order to keep billing costs to a minimum, all co-pays, co-insurance and deductibles are to be paid on the day of the visit without exception. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in. For your convenience, we accept credit and debit cards from Master Card, Visa, cash and check.

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In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an "out of network provider" for your insurance, the deductibles and coinsurance amounts may be higher. Your insurance policy, not our office, determines the amounts. After your insurance company processes your claims, you will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you. Patient balances are due and payable in full upon receipt of your statement. Accounts which remain unpaid after 30 days will be assessed a late fee of $5.00 per month. Delinquent accounts will be transferred to a collection agency or our attorney after 90 days and you will be discharged from our practice.

In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for as long as the law provides. A police report for theft of service and small claims court filing may also be initiated.

Please understand maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect.

There will be a $35.00 service fee for all return checks. If the check is returned for any reason, you have 7 days to contact our office and arrange another form of payment. Balance must be paid with certified funds (cashier check, money order or cash).

Credit card chargebacks will be subject to $50.00 administrative fee in addition to any other bank fees as assessed and prevailing party will pay the attorney fees as applicable. If there is credit card chargeback, we will forward your medical record for the service day in dispute, to the bank requesting it.

PRESCRIPTION REFILLS:
Please plan ahead for prescription refills. We encourage you to address refills at the time of your office visit. Any changes in medication, new prescription, or mail in prescription problems require an office visit. No prescription refills will be granted on weekends, after hours or during routine well visits.

We respect your time and every attempt is made to run on schedule. Therefore, we ask you to arrive on time for your appointment. If you are late, you may be asked to reschedule. If your doctor is running behind due to emergencies and you need to reschedule, please notify the office staff. If you choose to stay, your visit will be given the same consideration.

I have read and understand the above policy and I agree to abide by the terms stated within.

_____	_____	_____
Printed name of patient	Signature of patient/responsible party	Date