

A.M. Palanca-Capistrano, M.D., Inc.

Financial Policy and Agreement

We are committed to providing you with the highest level of service and quality care. Our office strives to help you receive the maximum allowable benefits of your medical insurance. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We exert our best efforts to bill your insurance accordingly and we rely on you to provide accurate information. We provide Medical and Surgical care to our patients, and for a fee routine eye exams when covered by your vision plan. If you have a managed care plan (HMO), a referral is required for every visit in order for services to be covered under your plan. If a referral has not been received, you will have the option to reschedule your appointment or pay for your treatment privately at the time services are rendered.

It is your responsibility to inform us of any changes to your insurance prior to your visit. If there were any changes in your insurance coverage and we were not notified prior to your visit, then you will be responsible for all incurred fees. These changes include your HMO Managed Care Plan or Medical Group.

It is the patient's/parent's/guardian's responsibility to:

! Be familiar with the benefits of your plan, including copays, co-insurances and deductibles. Copays and deductibles will be collected on the day of service.

! Be aware of our office policy that copays and deductibles are due at the time of service.

We accept cash, checks, Visa, MasterCard and Discover.

! Make sure a copy of your current insurance card is on file.

! Notify our office of any changes including insurance, addresses and phone numbers.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay the balance in full, please notify Perlita Manning (phone no. 858-524-6298) immediately to discuss payment plan options. All returned checks will result in a \$35 fee, which will be added to your account and must be paid before the next visit. Any balance remaining on your account 120 days past due will automatically incur a \$75 increase on the outstanding balance if it is being forwarded to a collection agency.

I understand that if I have an unpaid balance to A.M. Palanca-Capistrano, M.D., Inc. and do not make satisfactory payment arrangements or fail to make payments as arranged, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses

incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for A.M. Palanca-Capistrano, M.D., Inc. or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that A.M. Palanca-Capistrano, M.D., Inc. and the designated external collection agency are authorized to (i) contact me by phone at the phone number(s) I am providing, including wireless phone numbers, which could result in charges to me, (ii) contact me by sending emails, using any email address(es) I provide and (iii) contact me by sending correspondences, using any address(es) I provide.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

I understand and agree to this Financial Policy and Agreement.

Print name: _____ Signature: _____
Date: _____