

Kathy L. Anderson, DO, PA

510 E. Druid Road, Suite A ☎ Clearwater, Florida 33756 ☎ (727) 462-5242 ☎ Fax (727) 462-5350

Please read the provisions below and mark that billing class that represents you:

- Medicare only – Dr. Kathy L. Anderson will file Medicare for you. Dr. Anderson accepts assignment; however, you will still be responsible for the deductible and 20% that Medicare does not cover.
- Medicare / Supplement – Dr. Kathy L. Anderson will file both insurances. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days.
- HMO – Dr. Kathy L. Anderson will file to your insurance carrier. It will be your responsibility to obtain the necessary authorization by your primary care physician. Visits not authorized will be your responsibility. You will be responsible for your co-payment and any applicable deductibles or co-insurances.
- PPO – Dr. Kathy L. Anderson will file to your insurance carrier. You will be responsible for any coinsurance, copayments and deductibles. Patients going out of their network will be responsible for payment at a higher rate.
- Self-Pay- Payment is due at the time services are rendered unless prior arrangements have been made. Dr. Kathy L. Anderson will accept cash, checks, Visa, MasterCard and American Express.

** You may also be billed by the laboratory for any procedures involving pathological evaluation.

PAYMENT POLICY:

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a pre-paid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a \$20.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: _____ Date ____ / ____ / ____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file for authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card: _____ Date ____ / ____ / ____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare carrier automatically “crosses over”, we are required to keep a separate signature on file:

I request the authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP card: _____ Date ____ / ____ / ____