Kathy L. Anderson, DO, PA

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

Please read the provisions below regarding our office financial policies: **PAYMENT IS DUE AT THE TIME OF SERVICE**

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 as a courtesy. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility.
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. You will be required to pay for any visits without proper authorization from your primary care physician. 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, co-payments and deductibles. If Dr. Kathy L. Anderson is not in network with your insurance carrier your benefits are reduced and you will be responsible for payment at time of service.
Self-Pay	Payment is due at the time services are rendered. 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.**

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. For those patients, applicable co-payments and deductibles will be collected at time of service. We accept payment in the form of cash, check, or credit card. Coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments at the time of service. 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/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 on your behalf 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**____ / _____ /_____

Revision: 05/24/12 Carolyn Cox