Joe S. Levy, M.D., P.C.
6263 Poplar Avenue, Ste 525 Memphis, TN 38119
901-682-0430(ph)
901-680-0363 (fx)

INSURANCE AND FINANCIAL POLICIES

Insurance

Some providers participate or contract with certain insurance companies. If we do not participate with your particular insurance company at this time, we may still be able to bill as an out of network provider. Knowing your insurance coverage is your responsibility-please contact them with questions about your coverage before your visit. In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance and you will be required to pay for these services. Please check with you insurance company to find out if there are any exclusions in your individual policy. It is important to understand the verbal confirmation of coverage over the phone from the insurance does not guarantee payment by them. As it is not uncommon for an insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct. It is the patient's responsibility to follow up if a claim is not paid. Please be aware that you are responsible for the balance of you claim as decreed by your insurance company. _____**Initial**

Co-Payment and Deductibles:

_____**Initial**

By signing this agreement you agree to pay your co-payment, co-insurance and or deductible and any fees that your insurance company does not cover. Co-payment or co-insurance is an arrangement between you and your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients could be considered fraud. Please be informed about your co-payment, co-insurance and deductibles.

Proof of Insurance

_____**Initial**

All patients with insurance coverage must complete the patient intake forms and provide a current valid insurance card. This card will be copied and stored with your patient chart. If insurance coverage changes or expires, please provide a current card as soon as it is issued.

If you do not have insurance, payment in full is expected at the time of service rendered. _____**Initial**

Non-Payment

If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, your account may be referred to a collection agency. There is a $35.00 fee for returned checks to cover bank fees.

_____**Initial**

Authorization

I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account.
I agree to pay for all services rendered not covered by my insurance to notify this office should there be any changes to my insurance coverage
AND
I authorize the release of any medical or other information necessary to process any claims
AND
I authorize payment of medical benefits to Joe S. levy, M.D., P.C.

_____ _____ _____

Patient/Guardian Name Patient/Guardian Signature Date