

MID FLORIDA PRIMARY CARE

401 NORTH BLVD WEST
LEESBURG, FL 34748
352-728-4242

RAVI P. GUPTA, M.D.
NORMAN S. NOVIS, M.D.
(Board Certified in Internal Medicine)

17809 SE 109TH AVE
SUMMERFIELD, FL 34491
352-307-4200

OUR FINANCIAL POLICY

Thank you, for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read prior to any treatment.

In Network Insurance:

Regarding Insurance Plans where we are a participating provider, all co-payments and deductible are due at the time services are rendered. In addition, if your plan is an HMO plan our office must be listed as your primary care provider on your insurance card. In the event your insurance coverage changes, please notify us prior to being seen or you will be responsible for payment of services denied by your insurance plan.

Out of Network Insurance

Your insurance policy is a contract between you and your insurance company. We are not party to that contract. As a service to our patients we may accept assignment of insurance benefits after your second visit. We will file insurance claims for you; however we do require 20% coinsurance and deductibles to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us accurate information. We will assist your insurance company with additional information they may need in order to process a payment. If we are having difficulties with your insurance company, we may call you and ask that you, as the customer of the company, contact the company to request payment. We will file claims to secondary insurance, if the information is provided to us. In the event we do accept assignment as payment in full we require you to be pre-approved.

Medicare

We accept Medicare assignment. We will file claims for secondary insurance for you, if accurate information is provided. You will be responsible for annual deductibles, co-payments and non-covered procedures if they are not covered by Medicare and secondary insurance. If you do not have secondary insurance you are expected to pay 20% coinsurance and deductibles at the time services are rendered. We do not file any claims to tertiary insurance; this will be your responsibility.

ANY UNPAID INSURANCE CLAIMS OVER 60 DAYS OLD WILL BE PATIENT RESPONSIBILITY.

Usual and Customary Rates

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

Collection Service Fees

Any past due balances turned to collections agency are subject to a collection agency fee. The collection service fees are as follows: (Fees are subject to change in future)

- Balance under \$100.00 – collection fee is \$25.00
- Balance \$100.00-500.00 – collection fee is \$50.00
- Balance \$501.00-\$999 – collection fee is \$100.00
- Balance \$1000.00 or more – collection fee is \$150.00

Self Paying Patients / Credit Terms

All fees for services will be collected at time services are rendered. No credit will be extended without approval of our Office Manager or Billing Supervisor. Approval should be arranged in advance of treatment; however emergency credit may be extended on a case by case basis after services are rendered. Sometimes an advance payment will be collected for certain diagnostics or procedures. In case an account goes to collections, all discounts given as private pay on all pending invoices will be taken off.

FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.
WE ACCEPT CASH, CHECKS (with verification), VISA OR MASTER CARD

RETURNED CHECKS

Dishonored checks will be returned to patient only after acceptable payment is made. All Bank fees related to dishonored checks will be assessed to the patient. If the face value of returned check, plus all related Bank charges cannot be collected within 30 days, this office will refer this matter to Small Claims Court or to our Practice Attorney.

Thank you, for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Signature of Responsible Party

DATE: _____

Patient Date of Birth _____

Consent for Treatment _____