

Steven A. Crews, DO, PA  
Registration Form

Financial Policy, Assignment of Insurance Benefits and Privacy Practice Notice Verification

**PLEASE READ the information in each section and INITIAL in the column to the right indicating that you have read and agree to the policies/authorizations and sign the form below.**

INITIALS

**Financial Policy**

**Payment is expected when services are** rendered and upon receipt of statement of account from our office.

- We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment and or payment due toward your deductibles and co-insurance at the time of your visit.
- CO-PAYS-are collected prior to you being seen. Patients who pay a co-insurance will make payment at checkout which are estimated from the actual visit level only and may not include payment for testing or other procedures performed. Additional payment may be due for these services once we receive notice from your insurer. Your insurer will notify you of your responsibility in an EXPLANATION OF BENEFITS (EOB) statement. Please read your EOB carefully.
- We may request payment of outstanding balances prior to you being seen even if you have not been mailed a statement.

**Financial Responsibility**

- Keep in mind that your insurance policy is basically a contract between you and your insurance company. If your insurance company does not pay the practice within a reasonable period (120 days from date of billing) we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- We participate with a select number of Insurers and are participating Medicare Part B Providers. Contracts are subject to change without notice. We do not participate with all plans that those companies provide. It is your responsibility to keep your benefits information current and accurate. We verify insurance information before you are seen in order to allow us to determine your financial responsibility. .
- If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
- Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
- We do not participate with discount card programs. We will be happy to provide you with a receipt or HCFA 1500 claim form.

**Additional Important Billing Information**

- Please notify you if you have a secondary or additional insurance coverage so that we may bill your secondary insurance if necessary.
- By signing in and consenting to care you understand that you are responsible for payment of non covered services.
- If you fail to provide us with accurate information before you are seen you may be responsible for payment of the visit.
- We reserve the right to charge late fees, collection fees and fees related to court costs for collection of payment due.. If your account is transferred to a collection agency additional fees may be added by the collection agency.
- Statements are mailed to your address of record. If you move or change address, please notify our office in writing at the above address. Failure to update your records may cause your account to be sent to collections due to non payment.
- If your account is in arrears and we have sent you a statement we may additionally contact you by phone as a courtesy to notify you of your outstanding balance. Please avoid collection proceedings which may harm your credit by paying all statements promptly upon receipt.
- If you have any questions regarding your bill please contact the office by phone or in writing. Our billing manager is available at extension 2. The best time to call is from 11am to 12noon and 3 pm to 5pm (Mon-Thurs)
- We accept all forms of credit cards (American Express, Discover, Master Card and VISA).You may pay by phone or ask to complete a credit card form for automatic payment. Checks are processed via TELECHECK and will be electronically debited from your account. TELECHECKS will charge and process NSF as per policy. IF we are unable to process your check electronically we may ask for cash or credit payment prior to you being seen.
- Refunds are processed within 30 days or receipt of notification of payment from your insurer. We will apply any refund amounts to outstanding balances prior to forwarding refunds.

By my initials in the column and signature below I am indicating that I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

**Privacy Practice Notice**

I have had an opportunity to review a copy of the Steven A. Crews, DO, PA “Notice of Privacy”. I acknowledge that PHI (Personal Health Information) may be released in compliance with the practice policy for care and billing purposes. By signing this form I understand the policy and its limitation and that it will be in effect the duration of my care by Steven A. Crews, DO, PA or his designated agent. (please notify staff if you would like a copy of the Privacy Notice)

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of surgical / medical benefits to Dr. S.A. Crews, DO, PA for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Patient Name (please print) \_\_\_\_\_ Date: \_\_\_\_\_

Signature:\_\_\_\_\_

Relationship: (please circle)    SELF    PARENT    GUARDIAN    HEALTH CARE SURROGATE