Katherine J Frachetti MD, PC

1083 Delaware Ave. 3rd Floor

Buffalo, NY 14209

Assignment of Benefits Form

Release, Authorization and Financial Responsibility

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. We participate with most insurance's. It is your responsibility as the insured to know if our office participates with your insurance company and policy. It is also the responsibility of the patient to obtain a valid referral from their PCP prior to being seen, and making sure it is valid before each and every visit.

Assignment of Benefits

I,_____ , hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Katherine J Frachetti MD, PC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Katherine J Frachetti MD, PC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Katherine J Frachetti MD, PC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Missed Appointments

It is our policy to charge 50.00 for a missed appointment not cancelled within 24 hours of your appointment time. A second missed appointment in 12 months will be a 75.00 fee and termination form our practice.

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Non Covered Services

Please be aware that some and perhaps all of the services you may receive may not be covered by your insurance. You are responsible for these charges.

NON-Payment

If your account is 90 days or more over due, you will receive a letter allowing you one last opportunity to pay your bill in full within 10 days. If we do not receive payment you will be discharged from Katherine J Frachetti MD, PC for non-payment and your account will be sent to a collection agency. If your account is sent to a collection agency a charge of up to 50.00 may be added to your account to cover their services. Please be advised that you are the patient and ultimately responsible for any charges with Katherine J Frachetti MD, PC. Unpaid balances will be reported on your credit report.

Co-Payments, Co-Insurances and Deductibles and Proof of Insurance

We require a copy of your insurance card and your license, along with your co-pay or deductible payment at the time of service. As of August 1, 2009 the Federal Trade Commission passed the law that all Health Care Providers receive a copy of photo identification from all patients who will be using their Health Insurance to pay for their examination, in an effort to cut down on insurance fraud. To remain compliant with this law, Katherine J Frachetti MD PC has asked patients for their driver license so we could scan it into their charts. By law, a photo ID must be attached to your chart. There will be a $5 service charge for any copay not paid at the time of service.

For any high deductible plans or self -pay patients we require a 75.00 payment at time of service. Any remaining co-insurance or deductible will be billed directly to you after your insurance has processed your claim for services rendered. These balances are expected to be paid in full with-in 30 days.

Change of insurance

You are responsible to notify the office if your insurance changes so we can bill the appropriate insurance carrier in a timely manner. If you do not notify us within 30 days of the visit of applicable changes you will be responsible for all of the incurred charges.

Returned Checks

If you pay any balance with a check that is returned to the office for any reason, we reserve the right to charge your bank fees of, at a minimum, $35.00 and will only accept CASH or CREDIT of future visits.

Forms

If you require any forms to be filled out by our office you will be charged a fee of 20.00 that must be paid before you pick up your completed forms. Eg. Disability, FMLA, work, etc.