Barbara A. Lubin, MD LLC 756 Harrison Ave, Panama City, FL 32401
Phone (850)785-8246 **Fax** (850)785-8249 **www.lubinMD.com**

FINANCIAL POLICY

Welcome to Barbara A. Lubin MD practice. We are committed to providing the best possible health care experience to you and your family. Understanding your financial responsibility is an essential element of your medical care and treatment.

INSURED PATIENTS: Our office policy is to collect the patient's responsibility for medical care provided at the time of service. Our biller is here to help answer any questions you may have regarding your balances and payments. It is important to understand that your health insurance policy is a contract between you, your employer, and your insurance carrier. It is your responsibility to know what your policy benefits cover. We will collect your co-pay/ deductible or % at the time of service and file your visit to your insurance company. Deductible amounts are based on an ESTIMATE of your contracted rate. After your claim has been processed, you will receive a statement for any difference your insurance company applies to your responsibility. In the event your health plan determines a service is "not covered" you will be responsible for the balance upon receipt of a statement from our office.

UNINSURED/ SELF–PAY PATIENTS: We understand that not all of our patients have health insurance coverage. Our office policy for self-pay patients is very simple. All fees are due at the time of service at check-out. If you need to make payment arrangements please contact our biller prior to your visit. We utilize the same or lower Medicare fee schedule fees for uninsured individuals. Please note that the charges may vary based upon the complexity of your condition (i.e. level of service received) and other factors related to practicing medicine.

Minor Patients: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

PLEASE INTIAL EACH LINE:

--------- OUR OFFICE POLICY IS TO COLLECT THE PATIENT'S RESPONSIBILITY FOR MEDICAL CARE PROVIDED AT THE TIME OF SERVICE.

-------PLEASE BE AWARE, IF THE PHYSICIAN ORDERS A BLOOD WORK OR ANY TEST, YOU WILL ALSO RECEIVE A SEPARATE BILL FROM DIAGNOSTIC FACILITY FOR TEST CHARGES.

-------IN THE EVENT AN ACCOUNT IS TURNED OVER FOR COLLECTIONS PATIENT WILL BE RESPONSIBLE FOR ACCOUNT BALANCE + ALL COLLECTION FEES.

------- RETURNED CHECK FEE IS **$35.00**.

_____ANY CANCELLATIONS, RESCHEDULED OR MISSED APPOINTMENTS WITH LESS THAN A 24HOURS NOTICE, WILL BE ASSESSED A **$100.00 FEE**.

------I have read and understand Barbara A. Lubin, MD LLC PRACTICE financial policy, and I agree to be bound by its terms.

PATIENT SIGNATURE _____ Date: _____

RESPONSIBLE PARTY OF A MINOR SIGNATURE _____