3123 Fairview Ave E. Suite 200, Seattle, WA 98102
Main Line: 206-669-4171 Fax: 206-339-9544

FINANCIAL POLICY

This describes our Practice's patient payment procedures for all 'services' (including: exams, tests, supplies, forms completion) rendered to you. In general our Practice agrees to file accurate medical claims on your behalf to your insurance carrier. Patients are responsible for remaining balances resulting from appropriate claims processing. Please read all applicable sections and sign over the page for assignment of benefits to our Practice, and your acknowledgement of our policies.

PATIENTS WITH INSURANCE: Valid health insurance information must be provided to us to ensure appropriate reimbursement for your care. Patients are responsible for any pertinent deductibles, co- payments, 'non-covered' services, resulting from the insurance claim processing; as well as any documentation or updated information required to process the claim. Failure to provide accurate or required information to ensure proper claims processing will result in immediate patient (or guarantor) responsibility.

CO-PAYMENTS: Co-payments are due at the time services are rendered. If you are unable to pay your co-payment today, your appointment may be rescheduled or a payment plan may be permitted with a promissory note, at the provider's discretion.

MEDICARE PATIENTS: As stated above we will file to Medicare on your behalf, and with valid and effective secondary coverage will also forward claims accordingly. As participating providers in the Medicare program we will collect up to Medicare's allowed amount for covered services, between your insurance and direct payment obligations. Patients are responsible for any resulting coinsurance and deductibles not covered by your additional (secondary, tertiary) insurance. Patients are responsible for non-covered services/supplies under separate notice.

REFERRALS: Valid referrals or authorization numbers, as required by your insurance (including worker's compensation carriers), must be received before services are rendered. Otherwise your appointment may be re-scheduled or you may be required to pay for today's care, at the provider's discretion. Your prepayment would be refunded following our receipt of valid referral/authorization and insurance payment for the services we provided.

NO INSURANCE: Payment is expected at the time services are rendered, unless payment arrangements have been established with our Practice prior to your visit.

STATEMENTS: On a monthly basis our Practice will mail you an account statement for any outstanding balances due. Payment is expected within thirty (30) days. Failure to make timely payment will result in further collection actions.

PAYMENT METHODS: We accept payments by cash, check, MasterCard, VISA, and Discover.

AUTHORIZATION/ASSIGNMENT OF BENEFITS: For services rendered to me, I hereby authorize the release of private health information for the purposes of treatment and reimbursement for such care. In addition, I hereby authorize and assign benefits directly to MD Lab Solutions, LLC. I have read and understand the above described Practice payment policies and patient responsibilities pertinent to me (and/or guarantor).

SIGNATURE OF RESPONSIBLE PARTY: _____

PRINT NAME OF RESPONSIBLE PARTY: _____

DATE: _____