FINANCIAL POLICY
KENNETH E. BAIRD, M.D., P.A.

I understand that if I do not have a copy of the financial policy of Kenneth E. Baird, M.D., P.A. I will ask one of the staff for a copy.
Some health plans require that we inform you in advance that they may deny payment for "services not covered" and for "services not deemed by the health plan to be reasonable and customary or medically necessary."
Kenneth E. Baird, M.D., P.A. renders services that in their professional judgment are needed to provide quality medical care for you.
In order for us to collect from you for our services when payment is denied by your health plan, you are required to sign the following agreement.
Agreement: I have been notified by the physician that payment may be denied for "services not covered" or for "services not deemed by the health plan to be reasonable and customary or medically necessary" or for services that have been specifically requested by me, the patient. **If payment is denied, I agree to be personally and fully responsible for payment.**

Signature ________________________________ Date _______________________

REGARDING OFFICE VISITS, LAB WORK, AND ANY TESTING
It is your responsibility to know if Kenneth E. Baird, M.D., P.A. is in your insurance network.
It is your responsibility to check with your company if any tests we request are covered or need referrals.
Co-payment/co-insurance is due at the time of each visit.
A valid, current insurance card must be presented at each office visit.
If the service is not a covered benefit or if your health plan tells us you are not covered, **payment in full is due for all services rendered.** If your insurance company subsequently makes a payment, any overpayment will be refunded to you.

REGARDING YOUR HEALTH PLAN
Your insurance is a contract between you, your employer, and the insurance company. WE ARE NOT PART OF THAT CONTRACT. While we have an agreement with many of the health plans to provide services, you must resolve any questions regarding coverage with the insurance company. Not all services are a covered benefit in all contracts.
We will confirm eligibility with your primary insurance company. When we confirm eligibility, your insurance company will quote benefits but that is not a guarantee of payment.

I am assigning all medical/surgical benefits to Kenneth E. Baird, M.D., P.A. In the event of non-payment by my insurance carrier within 60 days, I understand that I will be responsible for full payment. I will then have to seek reimbursement from my insurance carrier. I also understand that I am responsible to provide the office with any insurance changes 24 hours prior to my appointment.
______________ (Patient initials)

I have read this document, understand and agree to these office policies and assignment of benefits.
I have received, read, and understand the current financial policy.
I understand that should I request that my records be sent to another family physician I am inactivating myself as a patient.
I have received, read and understand the summary of the notice of privacy practices.
I understand my financial obligations and am aware of late charges if my full balance is not paid in 30 days.

By signing below, I acknowledge that I have read this information and understand it completely.
Signature: ____ Date: ______________________

I do not agree with the financial policy of Kenneth E. Baird, M.D., P.A. and wish to discharge myself as a patient.
Signature: ____ Date: _____________________