Tamar K. Gottfried, M.D. P.L.C.

Board Certified In
Obstetrics and Gynecology

Thank you for choosing our office for your healthcare. We are committed to providing you with the best in medical care. Please understand that payment of your bill is considered a part of your treatment.
The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment being rendered.

WE ACCEPT: Cash, Check, Visa or MasterCard

REGARDING INSURANCE WHERE WE ARE A PARTICIPATING PROVIDER:

All co-pays and deductibles are due prior to treatment. Please be aware that some, and perhaps all of the services provided may be non-covered services or not considered reasonable and necessary under the Medicare Program, AHCCCS Program and/or any other medical insurance. In this event you may be considered financially responsible for any unpaid balances.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

MISSED APPOINTMENTS:

Unless canceled, in advance, our policy is to charge $25.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

RETURNED CHECKS: A fee of $30 will be applied to each returned check.

MEDICAL RECORDS: Requests for medical records can take up to two weeks to process. Copies sent to other providers for continuity of care, do not incur a charge. However, there will be a $25 fee for reproduction of records for personal use.

FMLA OR DISABILITY PAPERWORK: Due to the time constraint placed on staff, requests for FMLA or disability paperwork completion also requires a $25 fee, due at time of request.

Statements/Balance:

If we are contracted with your insurance company we will promptly submit your claim for you if you provide us with your insurance card and any other pertinent information. If your insurance company advises us that you are responsible for a portion of the balance we will then send you a bill. Patient bills are sent on a monthly basis.

Balances over 90 days old will be transferred to Collection Services and a collection fee equal to 30% of the balance will be charged to your account.

I hereby authorize Tamar K. Gottfried, M.D. to disclose information regarding my treatment and diagnosis to my insurance carrier(s) in an effort to be reimbursed for expenses incurred on my behalf. I authorize assignment of benefits to be paid directly to Tamar K. Gottfried, M.D. If my insurance company denies payment I agree to accept full responsibility for all medical fees, collection fees and or rebilling fees that may be incurred for any outstanding balance on my account. I agree to accept the financial obligation for these charges as determined by my insurance company or Tamar K. Gottfried, M.D.

I have read, understand and agree to this Financial Policy.

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Signature of Patient or Responsible Party Date