

FINANCIAL POLICY

Charges for office and telemedicine visits are due at the time of service including co-payments and balances due. There are fees associated with completing forms, custom letters, and medical records that are payable in advance (We require five business days' notice for these requests). Please ask our staff for information regarding fees for a specific form. For your convenience, we accept cash, check, MasterCard and Visa.

PPO PATIENTS: This office participates with most, but not all PPO insurance companies and plans. Knowing your insurance benefits is your responsibility. Your insurance benefit is a contract between you and your insurance company, not with Marina Village Medicine or its physicians. It is your responsibility to determine whether we are an in-network provider for your specific insurance plan. Your insurance company offers several ways to verify this. You can contact your insurance company directly via telephone (refer to the back of your insurance card and contact member services), or go to their website and use their online provider look-up tool. Once insurance coverage is verified, we will bill your insurance company for services rendered. If we are an out-of-network provider for your insurance plan, you will be responsible for the full amount of the visit. Cost for a standard office visit is \$185.00. You are responsible for your bills until your insurance makes payment, and responsible for any non-covered portions of your bill. This includes immunizations or procedures done in the office. If you have questions regarding your coverage, please contact your insurance company directly.

MEDICARE PATIENTS: We are a Medicare Participating Provider, which means that we accept Medicare's assignment as payment in full, once your deductible and co-payments have been made. We will bill Medicare for you. If you have Medicare supplemental or secondary insurance, Medicare will bill them directly on your behalf. All unpaid balances are the responsibility of the patient. There are instances where your supplement plan will require you to see an "in-network" provider. Please contact your supplement plan to confirm whether we are in your network of providers.

HMO PATIENTS: If you are covered by an HMO insurance plan, a Marina Village Medicine physician MUST be listed as the PCP (Primary Care Physician) on your insurance card for this coverage to be in effect. Co-payments will be collected at the time of service. Patients are responsible for payment of all non-covered services at the time of service. If you are not listed with a Marina Village Medicine physician at the time of service, you are responsible for all visit charges.

SELF-PAY: The cost of a standard office visit is \$185.00 and a standard telemedicine visit is \$100. Payment is due at the time of your appointment.

CO-PAYMENTS: All co-payments are due at the time of service. You are responsible for all office visit and telemedicine visit copays.

NON-COVERED SERVICES: Please be aware that some or all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full.



Jagmohan S. Khaira, M.D.
Elpidio P. Magalong Jr., M.D.

ACCOUNT BALANCES: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless they are arranged with an office staff member ahead of time. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from the practice.

CANCELLATION AND NO SHOW CHARGE: In order to run an efficient business we rely on patients to keep scheduled appointments. We set aside time and resources based on our schedule. If you cancel an appointment with less than 24 hour notice, you will be charged a "No Show" fee.

ASSIGNMENT OF BENEFITS/INSURANCE AUTHORIZATION

I, the undersigned, authorize my insurance company/companies to direct payment for medical services rendered to myself or dependents directly to Jagmohan S. Khaira, MD, Inc or Elpidio P. Magalong, Jr., MD. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand and agree to the above stated policies. This authorization and agreement shall be considered valid until revoked in writing. A copy is as valid as the original.

I acknowledge I have read and understand the above financial policy and Assignment of Benefits.

Signed: _____

Date: _____