COMPLETE PRIMARY CARE, P.A.

RABIN ROZEHZADEH, M.D.

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Office (908) 226-1810 Fax (908) 226-1833

FINANCIAL RESPONSIBILITY

ACCORDING TO YOUR INSURANCE PLAN, YOU ARE RESPONSIBLE FOR ANY AND ALL

- COPAYMENTS
- DEDUCTIBLES
- CO-INSURANCES

COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

SELF PAY PATIENTS ARE EXPECTED TO PAY FOR SERVICES IN **FULL** AT THE TIME OF VISIT.

IF YOU PARTICIPATE WITH A HIGH-DEDUCTIBLE HEALTH PLAN, WE REQUIRE A COPY OF FOLLOWING TO REMAIN ON FILE:

- HSA (HEALTH SAVINGS ACCOUNT) CREDIT CARD
- PERSONAL CREDIT CARD

IF PREVIOUS ARRANGEMENTS HAVE NOT BEEN MADE WITH OUR FINANCE OFFICE REGARDING BALANCES

- ANY ACCOUNT BALANCE OUTSTANDING LONGER THAN **45 DAYS** WILL INCURE A **15%** SURCHARGE FEE PER MONTH UP TO **45%**
- ANY ACCOUNT BALANCE OUTSTANDING LONGER THAN **120 DAYS** WILL BE FORWARDED TO A LAWYER AND/OR COLLECTION AGENCY.
- WHEN SENT TO LAWYER/COLLECTION AGENCY I WILL BE PROVIDED A LETTER OF TERMINATION AND WILL NO LONGER BE A PATIENT HERE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS

- A $40.00 FEE WILL BE CHARGED FOR ANY CHECKS RETURNED

I _____ UNDERSTAND THAT IF MY INSURANCE DOES NOT PAY, I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED.

February 13, 2013

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

PRINT PATIENT'S NAME OR LEGAL GAUDIAN DATE