888 S. Greenfield Rd. Ste. 101 Gilbert, AZ 85296
Phone: (480) 892-1300 Fax: (480) 507-7477
Dr. Brenden McRae, MD

PAYMENT POLICY

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate in, payment in full is expected at each visit. If you are insured by a plan we participate in but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage. When insurance is involved, we can file claims on your behalf in most cases. At times however, a portion of care is paid by the patient based on your specific plan. We will bill the responsible party for those services clearly outlined by the insurance plan that are the patients responsibility. Knowing your insurance benefits is your right and responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-Payments.** All co-payments must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-Covered Services.** Please be aware that some, and perhaps 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 whether at the time of your visit or herafter.

4. **Proof of Insurance.** All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your photo ID and a valid current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.

5. **Claims Submission.** We will submit your claims and assist you in any reasonable way to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. The amount owed to the office as outlined in your insurance contract is your responsibility.

6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Financial Policy.** We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our payment policy. Co-payments and fees that you are responsible for are due in full at the time of service. Should the account become delinquent, your account will be referred to a collections agency and you will be responsible for those fees. In this case, you may be asked to seek treatment elsewhere until your account is reconciled. Acceptable forms of payment are cash, Visa, MasterCard, Discover or American Express.

By signing below you agree that you have read and understand the above information and comply with these policies.

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Signature of Patient or Representative **Date**