



### **Insurance Acceptance Policy**

Responsible Party/ Insured's Name (Print) \_\_\_\_\_

Patient's Name (Print) \_\_\_\_\_

As a courtesy service we are more than happy to submit your insurance claim for you and we will accept payment from the insurance company. You must pay your deductible and the estimated portion of the full fee not covered by your insurance company the day of your appointment. To do this, we ask that you provide this office with all current insurance information for your claim as required by your insurance company. Without this information we cannot and will not submit or accept insurance assignment. You are responsible for your full fee.

We follow these guidelines:

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|---|---|
| 1 - 4 weeks<br>(Following your Appointment)         | We submit your claim and allow your insurance company up to four weeks to make payment.   |
| 4 to 6 weeks<br>(Following your Appointment)        | If we have not received payment, we will contact your insurance company and also notify you that your Insurance company has failed to pay your claim. We will resubmit the claim, only once if necessary. |
| Beyond the 6th Week<br>(Following your Appointment) | We ask that you pay your entire balance and you will have to contact your insurance company for payment to be made to you. We will not process any insurance Claims after the sixth week.                 |

Accounts over **120** days past due will be turned over to an outside collection agency for handling, and a 30% charge of the remaining balance will be added.

I understand any amount of insurance benefit (payment) quoted by this office is only an estimate based on information that I and the insurance company representative have provided to this office. Actual benefit (payment) amounts can vary greatly from the quoted estimate. I am aware that regardless of my insurance situation, I am responsible for the entire fee for all services provided. I am also aware that any remaining balance after insurance payment has been received is still my responsibility. Any insurance coverage disputes will NOT be handled by Dr. Kattchee's office. Any insurance payments received by **me** intended for Dr. Kattchees' office will be forwarded to the office immediately.

I have read the above statements and fully understand Dr. Kattchees' policy on insurance acceptance.

Signature: of Insured/ Responsible Party: \_\_\_\_\_