ASHOK J. KAR, M.D., INC.
ADULT UROLOGY & MALE INFERTILITY

CREDIT POLICY

Payment for services rendered will be collected in full at the time of service from all uninsured patients. As a courtesy to our patients, we will bill primary and secondary insurance companies for services rendered by the medical provider. Payment of medical and/or surgical benefits for which we bill will be assigned to the corporation. Co-payments and deductibles will be collected at the time of service and a $15.00 service charged will be added to accounts for each check returned by the bank for insufficient funds.

Our fees fall within the “Usual and Customary” guidelines as determined by the Orange County Medical Association and by most insurance carriers and are therefore covered up to the maximum allowable determined by those carries. Some insurance companies reimburse according to an arbitrary fee schedule which they call “Usual and Customary” but which does not reflect the current cost of care in our area.

Not all services are covered benefit in all polices. Insurance companies may arbitrarily select certain services that are not covered by the policy. In such a case, the patient will be billed for those services and will accept the liability.

Our office cannot accept responsibility for collecting insurance claims nor for negotiating settlements on disputed claims. Each patient, not the insurance company, is responsible for payment to this office. If we do not receive a response from the insurance company within the thirty days required by law, a statement may be sent to the patient who will be expected to meet the financial obligations incurred. Any future reimbursement made by the insurance company resulting in a credit balance on the claim will be refunded in timely manner.

Notification of change in name, address, phone number and/or insurance coverage must be given within a reasonable amount of time.

Your cooperation in complying with the terms of this policy is appreciated.

STATEMENT OF FINANCIAL RESPONSIBLILTY

I have read the above and understand that all medical and surgical charges incurred by me or my dependents for services rendered by Dr. Kar are my financial responsibility. All courts costs, attorney fees, and/or additional collection costs brought about in the attempt to collect this account area payable by me. All outstanding account balances over 90 days are subject to finance charges.

Signature: _____ Date: _____

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