K.K. BHATIA, MD

9460 NO NAME UNO, STE 135

GILROY, CA 95020

BILLING AND FINANCIAL POLICY: *Please read carefully.*

The following is the billing and financial policy for Dr. K.K. Bhatia's office. This policy is to help educate and help you understand your responsibilities as patient (parent of minor), your insurance and our office in processing your claims and payments. Your insurance benefit is a contract between you and your insurance company. Please review this information and sign/initial where indicated below.

I understand that it is my responsibility to make sure I provide the most current insurance information at the time of my appointment. We participate in most PPO's, SCCIPA HMO, and Medi-cal, however it is your responsibility to make sure that we are in network with your specific plan. Dr Bhatia's National Provider Identification number is 1598834517. Please provide this NPI number while checking if we are contracted with your plan. I understand if I fail to verify with my insurance that Dr KK Bhatia is within my network and my claim is denied, I will be responsible for the entire cost of the visit at a discounted cash pay rate.

Initials________

I understand that even if we are in network with your insurance, sometimes some services we provide are not covered by your plan or applied to your annual deductible or copay. I understand that it is my responsibility for the cost of services that are not paid by my insurance or applied to my annual deductible and/or copay.

Initials________

I agree to provide my secondary insurance (if applicable to you) and it is my responsibility to inform both insurance carriers regarding dual coverage so the primary and secondary insurance can be determined to avoid claim denials. It is my responsibility to keep up with my annual Coordination of Benefits mailed yearly by my insurance to avoid claim denials.

Initials________

I understand that if I decide to continue to see Dr KK Bhatia, if she is not in my insurance network or my newborn/child is not yet added to my insurance plan and is pending to be added, I agree to a discounted cash pay price for the visit and I will need to pay for the services

up front before being seen. I understand that I have a choice to see a provider within my network. If/when your child is added onto your insurance plan, you will only be reimbursed for your cash visit if/when the insurance pays on that claim. I agree if the insurance does not pay on the claim, I will not be refunded.

Initials________

I understand that I will be billed for any amounts due by me (copays, co-insurances, and deductibles) and that I am financially responsible to pay these amounts. I understand that if I do not pay this amount in full within 6 months the balance will be sent to an outside collection agency if I do not fulfill my financial obligations. I also understand that I will be responsible for any interest or legal expenses associated with those collection efforts.

Initials________

All forms and letters (written on your behalf) filled out by Dr KK Bhatia are subject to a $10 fee.

Initials________

A copy of your medical records can be provided upon receipt of signed record release. To obtain a copy of your entire medical record, there will be a $25 charge.

Initials________

I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my credit card for the amount specified and acknowledge that verbal requests can only be made by responsible party since we do not store credit card information.

Initials________

I understand that I will be charged a $20 fee if I cancel my appointment without giving a 24-hour notice and a $20 fee if I No Show my appointment. I agree to pay these fees.

Initials________

My signature below confirms that I have read these billing policies and understand my financial obligations to Dr. KK Bhatia's practice. If you may have any billing questions, please contact Jenna with Emiko Billing Services at (408)310-2776.

Patient's Name:__________________________ Date of Birth:__________

Signed:__________________________________ Date:____________

If person signing is not patient please provide:

Name:_________________________ Relationship to patient________________