**Lakeshore ENT, P.A.**
**Dr. Stephen Krzeminski, D.O.**
1305 Paluxy Highway, Ste A
Granbury, TX 76048

# PAYMENT POLICY

Thank you for choosing Lakeshore ENT. P. A., the office of Dr. Stephen Krzeminski.
Our office is committed to providing you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; due to this we have developed this payment policy. Please read it, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan that we are contracted with, but don't have a current insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. These services may include, but are not limited to, endoscopies, hearing exams and skin biopsies.

**3. Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Medicare beneficiaries are required to notify our office if enrolled in home health care or a skilled nursing unit. If our office is not notified, you may be liable for services rendered.

**4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and your current insurance card to verify coverage. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance is an **HMO**, you are required to obtain a referral from your Primary Doctor before your visit.

**5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**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. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

**7. Nonpayment.** If your account balance is past due, you will receive a letter requesting that you pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**8. Missed appointments.** Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your scheduled appointment, please give a 24-hour notice to avoid being charged. We reserve the right to charge for missed or untimely cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from this practice.

**9. Forms and Records.** There is a fee for the request of any forms, letters or medical records unless being forwarded to another physician for continued care.

**I have read and understand the payment policy and agree to abide by it's' guidelines:**

______________________________________ ______________________

Signature of Patient or Responsible Party Date