EAST VALLEY
Pulmonary Associates

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of commonly asked policy questions below. If you need further information about any of these policies, please ask to speak with the Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by Cash, Check, Visa, Mastercard, and American Express.

What is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below:

Office Visits and Office Services

If You Have…	You Are Responsible For…	Our Staff Will…
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage.	Payment of the patient responsibility for all office visits, x-ray, injection and other charges at the time of the office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive ar not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles and non-covered services for you. File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility- deductible, copay, non-covered services – at the time of service.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles and non-covered services for you. File an insurance claim on your behalf.
No Insurance	Payment in full at the time office visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to East Valley Pulmonary Associates, PLLC. I authorize Easy Valley Pulmonary Associates, PLLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Patient Signature: _____ Date: _____ / _____ / _____