THE ENDOCRINE CENTER, PC
CONCIERGE MEDICINE

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www.novaendocenter.com

OFFICE POLICY AND PROCEDURES

Thank you for choosing us as your Endocrinologist. We are committed to providing you with the best possible health care. The following policies and procedures are intended to help us serve you better.

Website

General information about our practices including directions, office hours and closures, and patient forms are available through our website. Please visit http://www.novaendocenter.com before your next visit.

Confirmation, Timely Arrival and Cancellation

Our office staff tried to accommodate your schedule when offering appointment dates and times. We usually confirm your appointment at least within 48 hours prior to the visit. If no confirmation is made either by phone, text message or email, the appointment will be cancelled**.** We request that if you must cancel your appointment, you kindly provide us **at least 24 business hours notice.**

Payment Options

Our office accepts payments by debit or credit cards (VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVERY), checks and cash for the services rendered. Payment is due on the day of service. If you need an itemize bill, we can provide it after the visit at your request.

Insurance Information

We accept most insurance plans, however we cannot guarantee that services (consultations, office visits, laboratory or diagnostic testing, etc.) will be reimbursed by your health insurance. We can provide you with diagnosis and procedure codes so you may inquire with your health insurance about their reimbursement rates. If the doctor participates with your insurance company, we will make sure that the information submitted to the insurance company is accurate and clearly describes the services that you have received during the office visit. We will work with your insurance to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy.
You MUST provide a valid insurance card at the time of the visit. When applicable, **the patient is responsible for all co-payments; deductibles or co-insurance amounts at the time services are rendered**. If your carrier denies coverage for a claim, you will be responsible for the balance, subject only to any restrictions imposed by law or contract. If our office does not participate with your insurance company, you must make payment in full at the time services are rendered with No Exceptions.

Secondary Insurance

Our office does not submit claims to secondary insurance if the secondary insurance does not accept electronic claims. **You should call your secondary insurance carrier and set up "automatic crossover"** so that your primary insurance company sends your claim directly to your secondary insurance company. Once automatic crossover is set up, your secondary insurance company should make payment directly to this office and we will not bill you for the balance. Otherwise, you will be responsible for the balance.

Patients with Medicare as their primary insurance should call 1800-633-4227 to determine if they are already set up for automatic crossover.

Payment Policies
Any balance for non-covered services are due within 30 days of the insurance payment or denial and will become your responsibility. Any balances that remain unpaid after 90 days from the service date, and are not subject to payment arrangements; the account will be evaluated and turned over to a collection agency or attorney for handling. If your account is turned over to a collections agency, you will be responsible for any fees imposed by the collections agency to collect your account. As these fees can be in excess of *fifty percent (50%)* of the outstanding balance, please be sure to pay your balance promptly.

The Endocrine Center reserves the right to change the office policy and procedures at any time and without notification. An updated form will be available upon your request.

Certification
I have acknowledged that I have read and fully understand the above financial office policy. I understand and fully accept the terms herein. I agree that a photocopy of this agreement shall be valid as the original. This authorization shall remain valid until revoked in writing.

_____ _____
Signature of Patient/Patient's representative Date

_____
Printed name of person signing above