



FINANCIAL POLICY

Thank you for choosing us to provide you with medical care. We are committed to serving you with skill and care. The medical services provided by our office are services you have elected to receive which implies a financial responsibility on your part.

COPAYS: Copayment is due at the time of service. Payments may be made by cash, check or credit card.

SELF PAY: Payment in full is due at the time of service if you do not have insurance or if our office does not participate with your plan.

MEDICARE: Dr. Prokurat is a Medicare participating provider. Medicare as well as your secondary insurance will be billed for you. You are responsible for copayment or deductible amounts stated by Medicare and your secondary insurance company.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance after payment has been received from your primary insurance.

HMO/PPO/MAJOR MEDICAL: Dr. Prokurat participates with most plans. You are required to pay your copayment stated on your identification card at the time of service. Any additional amounts due will be billed to you once your insurance has processed your claim.

REFERRALS/AUTHORIZATIONS: You are financially responsible for obtaining a referral or authorization, if required by your insurance, from your primary care physician. You may be financially responsible for any charges denied due to absence of a referral or authorization. Your scheduled visit may also be rescheduled due to the absence of a referral or authorization.

PATIENT BILLING: A statement of your financial responsibility will be sent to you after your claim has been processed by all of your insurance carriers. Your failure to pay your patient responsibility may result in your account being assigned for collection. Please contact our billing office if you have any questions or difficulty with your bill. **A fee of \$25.00** will be added to your account **for returned checks**.

BILLING SERVICE: Our office has contracted **Capital Medical Billing Solutions, LLC** to provide insurance and patient billing. You may contact them at **732-443-4038** with any questions regarding your statement.

I have read the above policies regarding my financial responsibility to Dr. Prokurat for providing medical services to me or my dependent. I agree to pay **NJ Advanced Surgical Solutions, PC** any amount due after insurance payment has been made by my insurances and any contractual adjustments have been taken. I understand that if I do not have health insurance I am personally responsible for the full amount of my bill.

I understand that it is my responsibility to inform Dr. Prokurat’s office if there is a change in my health insurance.

PATIENT NAME: _____

RESPONSIBLE PARTY: _____ **RELATION TO PATIENT:** _____

SIGNATURE OF RESPONSIBLE PARTY: _____ **DATE** _____

WITNESS: _____