Billing Update

melmed center
IM

Today's Date: _____ Patient's Name: _____ DOB: _____

FINANCIAL RESPONSIBILITY
We charge what is usual and customary for our area. Our office policy is that full private payment or insurance co-payment/co-insurance and/or deductible, as well as, account balances are due at the time of service unless prior arrangements have been made. The adult accompanying the minor patient will be required to pay in accordance with our policies.

Please understand that we will only bill insurance companies that we are contracted with. Furthermore it is your responsibility to follow up with the insurance company to insure the claim is paid within 60 days of the date of service. We must emphasize, that as health care providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. You are responsible for any remaining unpaid charge(s) as determined by your insurance company regardless of cause. This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 60 days or more and payment plans that are not kept current, may be subject to collection and associated fees.

By completing the information below, you assign your insurance benefits to be paid directly to Melmed Center. You also authorize Melmed Center to release any information which may be needed for processing of all claims; certification/case management/quality improvement; and/or other purposes related to the benefits of your health plan. Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit. Finally, **we require notification of insurance changes at least one week prior** to your appointment to avoid appointment delay and/or private pay expenses.

□ Private Pay □ Contracted Insurance

Insurance company: _____ Phone: (___)_____ Employer: _____

Group/Policy# _____ ID# _____ Employee SS# _____

Employee/Insured's name: _____ DOB: _____

Insurance mailing address: _____

Some medications may require Prior Authorization. Please call your insurance company and find out what provider your PHARMACY BENEFITS are covered through. Please note: This may be located on your insurance card (i.e. Medco, Prescription Solutions, Caremark, Express Scripts), **if not, we do need this information filled out in its entirety.**

Pharmacy Benefit Provider: _____
ID#:_____
Rx Bin#: _____ Rx Group#: _____

BY SIGNING BELOW, YOU ARE STATING THAT YOU UNDERSTAND AND AGREE TO ALL OF THE ABOVE

_____ _____
Signature of Patient/Responsible Party Relationship to Patient

4848 East Cactus Road, Suite #940 Scottsdale, AZ 85254
P (480) 443-0050 F (480) 443-4018
www.melmedcenter.com