**DANIEL F. HABER, M.D.**
221 E.HACIENDA AVE. SUITE C
CAMPBELL, CA 95008
408-374-5700

# Statement of Office Policies

Welcome to Daniel Haber M.D. Orthopedic and Sports Medical practice. We are pleased that you have chosen us for your medical needs. This policy statement will acquaint you with our office policies as well as your financial responsibilities. Our staff is happy to assist you with any questions or concerns you may have.

## Financial Responsibility

We wish to stress that the *financial responsibility for service rendered rests with patient* regardless of any) insurance coverage. We understand that some patients may have special needs. Patients with no insurance, limited coverage or those requiring special arrangements are asked to notify our staff immediately so that we may assist you.

- Patients without insurance are asked to pay in full at the time of *each* appointment. For your convenience we accept Visa and MasterCard.
- Patients with insurance are asked to pay their co-payment, if applicable, at the time of each appointment. Please not that your insurance policy is a contract between you and your insurance carrier. Therefore, we expect you to know both the benefits and the limitations of your policy. We will not enter into disputes between you and your carrier. As a courtesy, we may obtain a quotation of benefits from your carrier, but this quotation is NOT A GUARANTEE OF PAYMENT and we are unable to verify the accuracy of the information. Please note, your treatment plan is based on medical necessity NOT the limitations imposed by your insurance carrier. You are responsible for knowing the limitations of your policy and for requesting alternative arrangements prior, to exceeding benefit limits.

## Past Due Policy

Please be advised that any amount owing on your account over 60 days is due and payable in full by the patient. Accounts unpaid after 90 days will incur a 1.5% monthly charge (18% APR). Accounts which are over 120 days past due may be referred to our collection agency, unless specific arrangements have been made with out billing office.

## Returned Checks

There will be a $15.00 fee imposed for all checks returned to this office.

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## Appointment Cancellation Policy

We required a minimum of 24 hours notice for any cancelled or re-scheduled appointment. Failure to give the required notification may result in a $35.00 charge. If you fail to show for any appointment without any prior notification, you may be charged for the full time set aside for you. These charges will be billed directly to you as a missed appointment.

## Supplies

Due to varied and uncertain insurance reimbursement policies with regard to the purchase of supplies, we require payment in full for supplies upon receipt. If you request it, a bill will be provided for you to submit to your insurance carrier for reimbursement.

## Authorization and Assignment

I hereby authorize Daniel Haber M.D. to release any information deemed appropriate concerning my medical condition to my insurance company in order to process claims for charges incurred by me, and I release Daniel Haber M.D. Of any consequence thereof.

In consideration of the services rendered to me by Daniel Haber M.D., I authorize and direct payment to **Daniel Haber M.D.** for any sum owed on my account including any insurance company obligation and/or proceeds of any settlement in my name.

_____ _____

Signature Date

## Agreement to pay for services rendered

**(Not applicable for authorized workers compensation patients)**

I understand and agree that I am responsible and liable for payment of all charges assessed for professional services rendered to me by Daniel Haber MD. (regardless of any insurance coverage.)

I understand and agree that in the event my insurance company has not paid within 60 days, I am responsible for the balance, In the event that my insurance company forwards payment for services rendered by Daniel Haber MD. to me, I will promptly deliver such maybe to Daniel Haber M.D. In addition. I understand agree that if it becomes necessary for Daniel Haber M.D. to commence legal action for collection of any outstanding charges on my account. I will be responsible for all reasonable fees incurred to collect said charges including collection fees, court costs and attorney fees.

_____ _____

Signature Date