Pulmonary Associates Financial Policy

The following is the payment policy for Weill Cornell Medicine Pulmonary Associates. Please read and sign prior to your visits. This policy can be emailed to you prior to your visit:

It is the **patient's responsibility** to confirm that the doctor(s) that are being seen participate with the patient's individual insurance plan. ***If referrals are required, it is customary for the patient to contact their Primary Care Physician (PCP)/ General Practitioner (GP) and request insurance referral.*** You are required to inform us *immediately* of any changes in demographic (i.e., change of address, telephone number, pharmacy) or medical insurance information.

Participating Plans

You must present your insurance card and, if applicable, your insurance referral form prior to or at every visit. Once proper level of service has been determined by your Pulmonary physician, a claim will be submitted to your participating insurance carrier. **All applicable co-pays are due at the time of service.**

Non-Participating Plans

If it has been determined that our providers do not participate with you insurance plan/carrier, you are subject to our self-pay fees (which can be requested at the front desk). **Payment is due at time of service.** Self-pay patients are also responsible for payment toward any additional testing on day of service (i.e., Pulmonary Function Tests, blood draw {venipuncture}, Arterial Blood Gas {ABG} test, etc.).

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance carrier. Before agreeing to any visit or procedure, please coordinate with you insurance carrier to insure payment of claim. The patient is responsible for payment is regardless of any insurance company's arbitrary determination and customary rates.

Payment

For your convenience, the following payment methods are accepted: Cash, personal check, Visa, MasterCard, American Express, and Discover

Thank you for choosing Weill Cornell Physicians for your health care needs.

I have read the policy and I understand and agree to all terms.

_____ _____

Patient Signature Date

_____

Print Name