

FRANK SCAFURI, III, D.O., P.C.

Internal Medicine and Infectious Diseases

Dr. Frank Scafuri, III

Dr. Madhvi Rana

Dr. Azza Elemam

Derick Rias, RPA-C

Kristin Sweeney, RPA-C

Jennifer G. Scafuri, NP-C

FINANCIAL POLICIES

PATIENTS WITHOUT INSURANCE: If you do not have medical benefits, you must pay at the time of service.

PATIENTS WITH INSURANCE:

1. Our office will accept insurance assignment from a variety of insurance companies in order to help you meet your financial obligation for your treatment.
2. We will also process all claims related to your visit, including any vaccines that have been administered. Therefore, it is necessary for you to sign our assignment of benefits form.
3. Your insurance policy is an agreement between you and your insurance company. If the insurance company does not pay for your visit or any other ancillary services received from this office, you are responsible for your bill. Additionally, your co-pay is due before each visit.
4. If you discontinue care for any reason, your total account balance is due and payable immediately. If and when your insurance company sends us payment for services you have paid for, the payment will be returned.
5. In the event your insurance company requires you to obtain a referral for your visit or any other ancillary service received from this office, it is your responsibility to present this referral at the time of your appointment. In the event you do not have one, or the one you have on file has expired, your insurance company will not pay for the services rendered by this office and said payment will become your responsibility.
6. If, at the time of your visit, you do not have the required information to process your claim, such as your insurance card, no fault information or worker's compensation numbers, it is your responsibility to provide this information in a timely manner. If you do not provide this information and the claim is thereby denied, you will be responsible for these charges.

By signing below, you acknowledge that you have read the above Financial Arrangement Policy, you understand its terms and you accept full responsibility for all services rendered.

Thank you and welcome to our practice!

PATIENT'S SIGNATURE

DATE