



Saman B. Chubineh, M.D.

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North Tonawanda

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North Tonawanda, NY 14120

Lockport

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Lockport, NY 14094

Lewiston

5290 Military Road 10B

Lewiston, NY 14092

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask you to read and sign this form to acknowledge your understanding of our patient financial policies.

Our practice will work with you to help fulfill your payment responsibility. Ultimately, you are responsible for any outstanding balance that is not covered by your health insurance. This includes co-pays, deductibles, and services not covered by your insurance. To avoid interruption of your healthcare, we require payment at the time of registration.

Co-Payments

Patients who do not pay their co-pay on the date of their service will incur an additional \$25 fee in addition to their co-pay

Self Pay (no insurance) or Non-participating healthcare plans

If you are seeking treatment and do not have health insurance or are insured through a plan we do not participate with, you will be required to pre-pay an estimated amount which will range from \$100-\$200 for an initial office visit. Should you require procedures, you will be quoted a separate price that will also require payment prior to service. As these are estimates, you will either be billed for any remaining amount due or refunded for overpayment.

Form Processing

It is our office policy to collect \$10 for processing of any forms. We require payment upfront.

Missed appointments

There will be a \$25 charge for missed office appointments without 24 hours advance notice. Additionally there is a \$50 charge for missed procedures or those without at least 24 hours advance notice.

Collection Costs

Should you fail to pay any amount due under this agreement, you agree to be responsible for any collection costs, including court costs and reasonable attorney fees, incurred by this office in collecting the amount due

Questions?

We make every effort to continue to be able to take care of your healthcare needs. Should you have questions regarding your bill or have trouble making payments, please call our biller at 716-240-2296 and choose option 3 to discuss your concerns.

I certify the insurance information I have provided is accurate and correct. I authorize Saman B. Chubineh, M.D., to directly bill my insurance company on my behalf for services rendered. I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

X _____

Patient Signature, Authorized Representative or Responsible Party

_____ *Date*

Print Name of Patient, Authorized Representative or Responsible Party

Relationship to Patient