

# Cohen Medical Associates

Dear Patient:

It is a privilege for Cohen Medical Associates to take care of all of your medical needs.

Because we participate with so many insurance companies, (hopefully including yours), we must adhere to their policies and procedures. For instance, all copays must be collected at the time services are rendered.

It is our pleasure to submit your covered medical charges to your insurance company for processing. However, this does not negate your responsibility. If your insurance company does not pay the entire allowable charge or does not respond within 45 days, ultimately, you are responsible for the remaining balance, to be paid in full. If you do not respond to our request for payment within 45 days, there will be an additional \$20 administration fee (regardless of the amount of your balance). This helps to defray the costs of excessive billing. Any balance over 75 days will be forwarded to our collection agency. (There is also a \$25 fee for returned checks.)

Also, please note that although we have a laboratory in this office, not all insurance companies allow us to process your blood work. If your insurance company is one of those few, you have the choice of going to a lab that participates with your insurance or for a \$10 fee, we will gladly draw your blood and send it to the appropriate lab for you. (This fee is not covered by your insurance company nor is it considered your copay.)

If you have any questions, please do not hesitate to ask. You may also call your insurance company, prior to services being rendered, to inquire about your specific plan benefits, deductible and copays.

Patient's or authorized person's signature: I have read and understand the above information and agree to abide by the policies of both my insurance company and Cohen Medical Associates. I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct. I authorize payment of medical benefits to Cohen Medical Associates, Dr Robert Cohen/Dr Douglas Colman/Dr Lee Greene/Dr Jo Ann Yi and I hereby agree to pay any excesses not covered by insurance or in the event of no insurance. It is understood and agreed by the undersigned patient/representative that payment of all billing statements for services rendered by Drs Cohen/Colman/Greene/Yi is due upon receipt. Further, in the event that litigation is commenced to collect any amount(s) owed to Dr Cohen/Dr Colman/Dr Greene/Dr Yi, the undersigned patient/representative agrees to pay the costs and expenses of such litigation, including Dr Cohen's/Dr Colman's/Dr Greene's/Dr Yi's reasonable attorney's fees. No expiration date.

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Print Name

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Patient's or Representative's Signature

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Date