FINANCIAL POLICY

We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. The following is a statement of our Financial Policy, which we require to read and sign prior to any service. Please ask if you have any questions about our Financial Policy, fees, or your responsibility.

Insurance Coverage

Your insurance coverage is a contract between you and your insurance company. We are not a part of that contract. If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you must pay any co-payment and/or estimated co-insurance.

In the event that we accept an assignment of benefits, the patient is still ultimately responsible for all charges.

Usual and Customary Rates

Our lab is committed to providing the best service for patients and we charge what is usual and customary for our area. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. You are responsible for the timely payment of your account.

Non-Payment

If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. If the balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be unable to use our testing services.

Assignment of Insurance Benefits

I request that payment of insurance benefits be made of my behalf to Physicians' Laboratories of America, LLC. for any services furnished to me by the lab. I authorize any holder of medical information about me to release any information needed to determine benefits to my insurance carrier and its agents. I further authorize PLA or it's agent to verify employment and wage data in the event collection action becomes necessary.

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Signature of Patient or Responsible Party Date

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Signature of Co-Responsible Party Date