Charisse Litchman, MD

BILLING & OFFICE POLICIES
GUARANTOR PAYMENT AGREEMENT

Patient Name:_____

Charisse Litchman, MD is a provider ONLY with the following insurance carriers:

Aetna
Anthem Blue Cross Blue Shield
Out of State Blue Cross Blue Shield PPO
Medicare (non-par)

1. You are responsible for payment of any deductible and co-insurance as determined by your contract with your insurance carrier. Payments for your co-pays are expected at the time the service rendered. Also, please be aware that many insurance companies have additional stipulations that may affect your coverage.

2. Dr. Litchman does not participate with any of the Connecticut Medical Assistance (State Welfare) plans.

3. If you insurance plan requires your Primary Care Physician to obtain a referral, it is your responsibility to provide it before you are seen. If you do not have an active referral on the day of service you are expected to pay upfront and pursue your insurance company for reimbursement.

4. If you have a managed care plan in which we participate, we will bill your insurance company directly for our services. Please provide us with CURRENT and ACCURATE insurance information.

5. Dr. Litchman is a Medicare provider but she does not participate with Medicare. You must pay all fees at the time of service. As a courtesy, we will submit the claim for you and direct payment to be sent directly to you. If the claim is denied, it is your responsibility to pursue Medicare for your reimbursement.

6. Co-payments not paid at the time of service will be charged a $20.00 late fee.

7. We require 24 hour advance notice should you need to cancel or reschedule your appointment. Failure to provide such advance notice will result in a $100.00 charge.

8. Routine medication refills must be requested during office hours. We reserve the right to charge a $35 administration fee for after hour renewals and refills.

9. We require 48 hour advance notice for medical forms to be completed by Dr. Litchman and/or her staff. There is a $35 administrative fee for completion of documents. This is not limited to DMV and/or Return to Work forms.

10. If you are experiencing a financial hardship, please contact the Office Manager before your scheduled appointment to discuss a payment plan.

11. If you have private insurance with which Dr. Litchman does not participate, the patient is responsible for filing the claim with his/her carrier.

12. Self-Pay patients unable to pay at time of service may be asked to reschedule their appointment.

13. Accounts that are more than 90 days overdue are subject to an interest charge of 18% per annum. We accept cash, check, Mastercard and Visa.

14. If you are receiving Botox injections, you will be asked to leave a credit card on file at the time of service. We will pre-authorize the injection if required by your insurance company. We will not charge your card unless the claim has not been paid by 45 days. It will be your responsibility to pursue payment from your insurance company. We will notify you of the charge on your card and will send you a copy of the receipt.

15. If your account is not paid in a normal billing cycle, your account will be placed in collection. If you do not pay an outstanding balance within a reasonable period of time, you will be discharged

from our practice. We will send you a medical records release for your signature so that we can send a copy of your records to your new physician.

16. If we must refer your account to a collection agency or to a law firm to collect an unpaid balance, you will have to pay the cost of collection as well as any balance in order to remain a patient of our practice. You are responsible for band charges associated with checks not honored by your/our band.

I have read and understood the billing policies and my financial responsibility to Charisse Litchman, MD for providing services to me or the above named patient. I have read and understood the office policies. I certify that the information I have provided is true and accurate. This agreement is effective for all visits from this date forward.

Signature of Patient or Legal Representative_____

Print Name_____

Date_____

WORKERS COMPENSATION
AND/OR
MOTOR VEHICLE ACCIDENT PATIENTS

Prior to services being rendered, patients are required to inform Dr. Litchman of a related Workers Compensation or Motor Vehicle Accident.

I understand that the failure to communicate this information to Dr. Litchman will release Dr. Litchman of her obligation to coordinate or submit necessary paperwork related to my accident and that I am fully responsible for all charges related to my incident.

Signature of Patient or Legal Representative_____

Print Name_____

Date_____