MAINLAND
PULMONARY ASSOCIATES

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing mainland pulmonary associates as your healthcare provider. We ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. We will attempt to verify coverage and benefits, but be aware that health insurance is a contract between the member and the insurance company, not the physician and the insurance company.

Please read carefully and acknowledge you understand Mainland pulmonary's financial policy:

____I acknowledge I am financially responsible for all services rendered by mainland pulmonary associates.

____I acknowledge all payment estimates are due at the time services are rendered.

____I acknowledge that all estimates of payments are just estimates and may not show correct value. Actual payment may vary resulting in a remaining patient balance even after insurance has processed the claim.

____I acknowledge that if I want more precise estimate, I may request a pre-treatment estimate which may take 2-4 weeks.

____I acknowledge I am responsible for payment on all services if not paid by insurance within 45 days of service.

____I acknowledge failure to pay any past due balances are subject to referred to an outside collection agency and collection fees and/attorney fees/or court cost I am responsible to pay.

___YES or ___NO (**Do you have an advance directive in place**).

Appointment policy

At mainland pulmonary associates, we make every effort to value your time. If our attempts to reach you either by text, email, and/or phone calls are unsuccessful, We will cancel and or reschedule your appointment. This will allow us the time to fill the time slot with those waiting for cancellation. A missed appointment will be considered not showing up to your confirmed appointment and failing to notify the office within 24 hour time frame to cancel or reschedule.

You must cancel your appointment more than 24 hours in advance in order to avoid the $50 no-show/ cancellation fee.

There will be a $50 no show/no cancellation fee imposed by our practice.

We appreciate all our patients. With your cooperation we will be more able to keep our schedule "on time", accommodate emergencies, and help patients on the waiting list.

NAME: _____

Signature of Patient: _____date_____