Nicholas H. Mast MD, Inc.

Financial Policy

Welcome Dr. Mast's Office

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. If you have questions about your account, charges, insurance, or payments, please ask to speak with one of our Billing Representatives. They will be happy to review details of charges and payment with you.

Please have available at the time of your visit the following insurance and identification information:

1. Your insurance identification card so that we may copy the front and back of the card for accurate insurance information.
2. Your drivers license so that we may copy the card for accurate demographic and patient specific data.
3. Your referral or authorization for services when applicable.

Payment Policy

Payment in full is expected at the time service is rendered. For your convenience, we accept cash, check, or credit cards. As a courtesy, we will bill your insurance company on your behalf. Please note that in the event of non-payment, the account may be placed with an outside collection agency and the expenses will be added to your account balance. Balances that exceed 90 days from the date of service may be charged a finance fee of 1.5% per month. If you have any questions, please feel free to ask one of our billing representatives.

Self-pay Accounts

If you do not have a valid insurance plan to cover the cost of our services, you will be required to make full payment at the time of service.

Insurance Plans

Dr. Mast is not "In-Network" with all insurance plans. For those insurance plans in which he is "Out-of-Network", you will be considered a **Self-pay** and will be expected to pay for office services at the time they are rendered. Please see "Surgical Service Fees" below for surgical payment policy. We will always bill your insurance on your behalf, however, it is ultimately your responsibility to become familiar with the details of your insurance plan coverage. We recommend you contact your insurance company prior to any service so you may understand your allowable benefits. If you have a PPO or HMO insurance plan, we will collect the required co-payment, co-insurance, and any deductible that is due at the time of the visit. In the event that your health plan determines a service to be "non-covered," we will bill you, and payment is due upon receipt of that statement. Any amount not paid by your insurance company within 30 days will be billed to you.

Medicare
If you are on an Medicare plan, we will bill your Medicare insurance and your supplemental, if you have one.

Third Party Liability Injuries
For patients who have been involved in a liability/third party accident, payment in full is expected at the time of service. Third party billing is not accepted.

Workers' Compensation
If you are involved in an "on-the-job" work injury, prior to seeing the physician, the following information must be obtained and verified prior to your visit:
Date of Injury
Case or claim number
WCAB#, if applicable
Workers' Compensation carrier information
Adjuster's name
Adjuster's telephone number
Employer

Insurance Updates
Due to frequent changes in insurance plans and the benefits offered under those plans, our staff is required to review and update your insurance information on a regular basis.

Surgical Service Fees
During the surgical planning process, we will contact your insurance company to determine your financial responsibility. The amount we determine will need to be paid shortly after scheduling surgery to secure your surgical date and is fully refundable should you need to cancel. If payment is not received by the given due date, surgery may be canceled or post-poned. For Self-pay patients or those with an "Out-of-Network" insurance plan, Dr. Mast's surgical rates, along with financial assistance information may be found on our website, www.sfhips.com. .

I understand that Dr. Mast will bill my insurance as a courtesy, and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for payment for all services.

_____ _____ _____
Name of Patient (please print) Signature of Patient or Responsible Party Date

_____ _____ _____
Interpreter/Representative Name Interpreter/Representative Signature Date