Yale M. Kadesky, M.D.
Statement of Patient Financial Responsibility

Dr. Kadesky appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

As the patient, you are ultimately financially responsible for the medical services you receive. You are responsible to furnish us with accurate and up to date insurance information. In addition, it is your responsibility to know your insurance benefits, including coverage for the office visits and surgery if applicable.

- If you do not have insurance coverage on the date of services, the entire cost will be collected at the time the service is provided.

If you have medical insurance:

- You are responsible for co-pays, co-insurance as well as the deductible.
- If your insurance requires referral and/or preauthorization, it is your responsibility to obtain it. If it has not been received before your appointment you will be charged as a cash pay patient or your appointment may be cancelled.
- Co-payments and deductibles are due on the day of service.
- Failure of your insurance carrier to pay claims within 90 days of filling is viewed as a refusal to pay; therefore, you become financially responsible. This usually results when the insurance carrier is holding the claim for review of pre-existing conditions and other insurance information requested from the patient.
- It is our policy to send 2 statements for past due. If payment is not made, a courtesy call will be made to try to make payment arrangements. If it is not resolved, the account will be sent to the collection agency.

Consent for Treatment and Authorization to Release Information

I hereby authorize Yale M. Kadesky, M.D., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessments and treatment procedures.

I further authorize Yale M. Kadesky, M.D., to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____