

MASSOUDI AND JACKSON NEUROSURGICAL MEDICAL ASSOCIATES
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PAYMENT POLICY

It is the policy of Massoudi and Jackson Neurosurgical Medical Associates to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card (front and back) and/or complete billing information is required and must be presented before services are rendered. The billing information required is the correct billing name, address, phone number, the I.D./subscriber number, and group/policy number. We also need the name of the insured along with the date of birth and name of employer.

Enrollment in an insurance plan is not a guarantee of payment.

Deductibles, co-payments and patient responsibility amounts are due at the time of service.

Massoudi and Jackson Neurosurgical Medical Associates does not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan **before** services are rendered. This also applies to any facility or provider your doctor may refer you to.

Any portion of the balance not paid by the insurance company due to patient co-pays, deductible amounts, noncovered services, services deemed by the insurance company as not medically necessary, doctor nonparticipation in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or responsible party. It is the policy of this medical group to receive payment in full 90 days from the date of service.

HMOs and other insurance plans that require an authorization for treatment from a Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self referrals and services provided by out of network providers are usually not covered. **Authorization does not guarantee payment by the insurance company.**

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Balance is due and payable 90 days from the date of service. Delinquent balances may be referred to an outside agency for collection.

We accept cash, check, money order, and Mastercard, VISA, or Discover as your method of payment.

The fee for a returned check is \$15.00.

I have read the above policy and understand I am financially responsible for all medical services rendered.

Signature of Patient or Responsible Party

Date

Print Name