



## **Patient Statement of Financial Responsibility**

Thank you for choosing Jeffrey A. Kantor, MD for your healthcare needs. Our staff is committed to enhancing the quality of your care and overall health. This policy statement and release has been designed to inform you of our policies and answer your questions regarding payment of services.

Please be sure that you have read and understand all the information provided in this statement before signing the release. As our patient your signature is both binding and acknowledges your understanding and compliance with our policies.

### **Payment for Office Visits**

For the convenience of our patients we accept cash, Visa, Master Card, American Express, Discover, traveler's checks and personal checks. Co-payments and deductibles required by individual insurance plans are due at the time the services are rendered.

**Returned checks are subject to a \$30 return fee.**

### **Payment for surgery**

Co-payments or deductibles toward surgery are the patient's responsibility and must be paid prior to the date of surgery. If payment is not received prior to surgery it will be postponed.

### **Self Pay Patients**

We welcome self-paying patients when insurance coverage is not available for our services. Patients without insurance are asked to assume full financial responsibility for the office visit and medical services rendered during the time of service. *If for some reason full payment cannot be made at the time of service please speak with an administrator prior to your office visit to determine if reasonable payment arrangement can be established.*

### **Cancellations and Missed Appointments**

In order to be respectful of the medical needs of others please be courteous and call our office at least 24-hours in advance if you are unable to attend or must reschedule an appointment.

For your convenience our phone lines, (661) 945-4900 and (661) 259-2110 are covered 24-hours a day.

**Medical Supplies and X-Rays**

Your insurance plan may cover medical supplies and x-rays partially or not at all. We will do our best to abide by your insurance policy and bill them appropriately. However, you will be billed directly if your insurance company denies charges for medial supplies and/or x-rays. Upon request, we will provide you with a cost estimate of all services and supplies.

**X-Ray Film/Medical Record Ownership**

Medical records, diagnostic films and tracings belong to the physician’s office or facility where they were made. The fees paid for the x-rays and other diagnostic imagines are for the expertise, equipment, and supplies used to take the images and diagnose them. You, the patient, have a right to obtain copies of your films if you make a written request that they be provided to you and not to anyone else. We, the physician, will charge you the actual cost of making the copies of your films and/or medical records.

This information can be found under  
Health and Safety Code Sections 123100 through 123149.5  
You may check the laws at the following web site: <http://leginfo.ca.gov/calaw.html>

**Medicare Patients**

We accept Medicare assignment of covered charges. Patients will be billed for the \$100.00 annual deductible or any uncovered charges unless the patient has a supplemental insurance.

**Worker’s Compensation Patients**

We must have prior authorization to treat from either the employer or the insurance carrier agent. Should the employer or carrier subsequently deny validated worker’s compensation service, such charges will be the financial responsibility of the patient.

**Personal Injury Patients**

Patients with representation must have signed lien agreement and authorization prior to being seen. It is the patient’s responsibility to communicate a change in status to our office if services had previously been billed to a private insurance carrier.

**RELEASE**

I hereby acknowledge that I have read, understand and agree to comply with all policies outlined herein. I also acknowledge should my account go to collections, I will be charged the collections service fee in addition to all outstanding balances.

\_\_\_\_\_  
*Signature of patient/ Guarantor*

**Date**\_\_\_\_\_

\_\_\_\_\_  
*Print name*