SANJIV GOEL, M.D. INC.

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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your health and treatment being successful. Please understand that payment is considered a part of your treatment.

The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our "Patient Information Form" before seeing the physician.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. We may or may not be a party to that contract. We may accept insurance benefits; however, it is your responsibility to pay any co-payment, yearly deductible and portions of your bill for which your insurance does not pay. That amount paid to you/physician is the amount of insurance coverage which you have purchased. The balance is due whether your insurance company pays or not. We cannot bill your insurance unless you provide us with all your insurance information.

The benefits that are specified in your contract bear no relationship to the value of my services. On insurance payments the phrase "more than allowable charge" or "exceeds usual and customary amount" is the standard language used by the insurance companies to state that your insurance does not cover the full amount of the bill, and again, bears no relation to the value of my services of fee. Please be aware that some and perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Each patient, not insurance company, is responsible for payment to this office. Our office cannot accept responsibility for negotiating a settlement on a disputed claim. Regardless of any claim pending, if a balance is due, a statement may be sent to you.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Policy.

Signature of Patient / Responsible Person Date

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