JACQUELINE M. STOKEN, D.O., P.C.
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FINANCIAL POLICY

Welcome to the office of Jacqueline M. Stoken, D.O., P.C. We are happy that you have chosen our center for your healthcare services. To help you understand the financial coverage related to your treatment, we have the following statements, which explain our financial policies. Please read this carefully so you understand – and consent to abide by – the policy terms.

Co-payments, proof of insurance, and a photo ID are required at the time services are rendered. For your convenience, we accept cash, checks, MasterCard, Visa and Discover.

We file insurance claims for our patients. Please provide us with your correct and current coverage information. **After the insurance company has reviewed your claim and paid their portion, any balance left becomes your responsibility and must be paid within 6 0 days of the date of service. All unpaid balances will accrue interest at a rate of 2% per month.** This includes any deductibles, co-pays, co-insurance or non-payment/non-covered services you have on your policy. If you have questions on your coverage please contact your employer or insurance company for clarification.

Charges for treatment given to **minor children** become the responsibility of the parent who authorizes the treatment.

If you have a **workmen's compensation** related problem, please bring the name and address of your employer, the insurance company covering your workmen's comp claim, your claim number, your case manager's name and telephone number to your first appointment. We are unable to process an insurance claim for you without this information and you will be responsible for payment at that time.

If you have a **motor vehicle or personal injury** related problem – **payment at the time of service will be expected or we can submit claims to your health insurance. Please note, we do not bill third party insurance companies.** If you choose to pay for services in lieu of submitting to your health insurance, the charges must be paid in full at the time services are rendered. We will provide you with a copy of your medical bill that you may submit to the liability insurance company for reimbursement. Your attorney can advise you on reimbursement of any unpaid medical expenses.

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to be made directly to the physician or supplier of services rendered. Our office cannot accept responsibility for collecting an insurance claim or for negotiating disputed claims. Insurance reimbursement is a contract between you and your insurance company. In consideration of the services rendered to me by this physician, I am obligated to pay said office in accordance with the physician's financial policy and credit terms as outlined above.

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Patient signature Date

Board Certified
Physical Medicine and Rehabilitation
Independent Medical Examination
Holistic Medicine