Debra Jaliman, MD
931 Fifth Avenue
New York, New York 10021

Patient Financial and Insurance Agreement

We accept many, but not all, insurance plans. It is your responsibility to verify if we participate with your insurance plan. Insurance verification does not guarantee your insurance will pay for services. Payment of co-pays or non-covered services, when applicable, is required at the time of service. Payment of co-insurance and/or deductibles is due once we receive the EOB (Explanation of Benefits) from your insurance company. If you have a deductible that needs to be met for the year, there will be an amount you pay for health care services before your health insurance begins to pay.

We accept assignment of Medicare benefits. However, it is your responsibility to pay for services not covered by Medicare.

We accept cash, debit cards, Visa, MasterCard, American Express and Discover for payment of services. Please leave your credit card on file to ensure that any balance owed is paid accordingly. You can leave the credit card on file below for one year.

This represents a payment agreement for services rendered, between Debra Jaliman, M.D. and the undersigned patient. In the event that any suit or action is instituted to enforce payment for services rendered, the prevailing party in such suit or action is entitled to recover from the losing party all fees, costs, and expenses associated with enforcing payment for services rendered, including without limitation, such reasonable fees and expenses of attorneys and accountants, which shall include, without limitation, all fees, costs, and expenses of appeals.

I have read, understood and agreed to the above office and financial policies. I hereby attest that I have given accurate information regarding my insurance and demographics and understand that I am solely responsible for payments not made by my insurance company or non- covered services.

I agree that when the EOB (Explanation of Benefits) statement is available, I will be charged any remaining balance due on this credit card. I understand this is a 1 year authorization for the use of my credit card.

Start Date (today's date): _____ End Date (1 year from start date): _____

Credit Card Number _____

Exp:_____ Sec. Code:_____

_____
Patient Signature

_____
Print Patient Name

I agree that my credit card will be charged $50 if I NO SHOW or do not call to cancel 24-hrs prior to my appointment