Naresh G. Rana, M.D., P.A.
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Patient Financial Responsibilities and Policies

Thank you for choosing Naresh Rana MD PA for your medical needs. The following patient financial responsibilities and policies have been established to assist us providing the highest quality medial care.

Insurance: It is your responsibility to know and understand your coverage and benefits. As a courtesy, we will file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number and relationship to the patient to file all claims. Patients are responsible for all fees at the time of service that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received. At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly.

No Insurance: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. Cash or checks are accepted.

Returned Check: There will be a twenty dollar ($20.00) charge assessed for any check returned by your bank for any reason.

Past Due Balances: Accounts that are not paid within sixty (60) days from the date of service may be sent to our in house collections department. A collection fee may be added to the balance. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records: If you request a copy of your medical records, you will be required to sign a medical record release form. Please allow up to 14 days for this request to be processed.

Refunds: If you have a credit on your account, we will gladly refund the amount within thirty (30) days of your request. You must provide a correct mailing address for your refund to be sent.

Patient Acknowledgement:

I, _____ (print name) have read and agree to the Patient Financial Responsibilities and Policies. I agree to pay at the time of service. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.

Patient's or Responsible Party's Signature **Date**

Witness Signature **Date**