Access Family Care, LLC
Tazeen Zaidi, MD — Family Medicine

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Financial & Insurance Policy

Please read carefully. This policy explains your financial responsibilities as a patient of Access Family Care, LLC.

> **Please Note: Please print this completed form and bring it to your appointment. Do not return this form by email or upload it online.**

We require all patients to pay at time of service by cash, check, debit, or credit card. Credit card or health savings account debit card are the preferred method of payment. You will be charged at the time of your visit for any outstanding deductible, co-insurance, or co-payment due, as well as any fees for services not covered by your insurance plan.

HOW YOUR INSURANCE PLAN WORKS

Medicare

What you do: Pay your deductible and co-insurance (20% of the allowable amount). If you request any services Medicare does not cover, you agree in writing to pay our regular fee for those services.

What we do: We will file Medicare for you.

Medicare + Secondary Insurance

What you do: No payment due at time of service.

What we do: We will file Medicare and your secondary insurance for you. For secondary insurance we do not contract with, see "Insurance We Are Not Contracted With" below.

Cigna, Aetna, Freedom, United Healthcare, BlueCross/BlueShield, Florida Healthcare Plans, AdventHealth, Bright Health

What you do: Pay your deductible, co-insurance, or co-pay at time of service.

What we do: We will file your insurance for you.

Insurance We Are Not Contracted With

What you do: Pay for the visit in full at time of service.

What we do: We will submit the claim as a courtesy, and you will receive direct payment from your insurance plan.

Worker's Compensation, Automobile Accident, Disability Evaluation

What you do: Please contact the respective agency directly regarding payment for these services.

What we do: —

ADDITIONAL CHARGES

- No-Show fee: $25 for scheduled appointments cancelled without at least 24 hours' prior notice.
- Completion of Forms fee: $35. Please allow up to 3 business days for forms to be completed.

By signing below, you state that you understand the above Additional Charges.

AGREEMENT TO PAYMENT POLICY

I have read and understand the Financial & Insurance Policy of Access Family Care, LLC as described above. I agree to be financially responsible for any charges not covered by my insurance, including copayments, coinsurance, deductibles, self-pay balances, and the additional charges described in this policy.

Patient Name (Printed) *

Date of Birth *

Signature *

Date *

Relationship to Patient (if not patient)