CPI Physicians, P.C.

319 South Manning Boulevard – Suite 116 * Albany, New York 12208

Phone (518) 459-1800 Fax (518) 459-1818

Self-Pay Policy

Thank you for coming to CPI Physicians, P.C. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand the responsibilities that they and their families have for payment of our fees. If at any time you have questions or problems with our fees or payment process, please do not hesitate to talk to our billing department at the number above.

We require that our patients promptly pay ALL charges that we present to them. In some cases, our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means that we have taken any such adjustment into account and that you must still pay the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement.

If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with the factual information about your care and billing to help you discuss this with them, but we will still require you to promptly pay the entire charge we present to you, even if your issue is with the program is not resolved.

Payment for our services is due at the time that those services are provided to you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes, among other things, copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by, insurance or government programs. We may also present charges to you by written statement via the mail (and specify any other method used) following a visit. If we do this, we expect that each charge will be paid in full by return mail (and specify any other method permitted and the time for payment) the first time it is presented to you. We or our agents may send you statements and reminders of charges made and amounts that we believe must be paid, or may call you about the same. By accepting our services, you are consenting to receive these communications. Please be advised that non-payment of charges may be turned over to a collection agency and/or this practice's attorney.

I have read the above statements and understand them and my responsibilities with respect to being a self-pay patient. I also understand my financial responsibilities with respect to paying all charges I am presented with for services rendered which are not covered by an insurance or government program. I waive my rights to insurance benefits if I have not accurately informed you of my insurance or government coverage prior to my treatment.

I understand the above information, and will be financially responsible for the following patient:

NAME OF PATIENT (Please Print): _____

SIGNATURE OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____ SELF _____ OTHER: Please specify - _____

DATE: _____ OFFICE STAFF WITNESS: _____