9821 South May Ave. Suite C
Oklahoma City, OK 73159

Phone: (405) 708-7876
Fax: (405) 259-5978

TAMBOLI
EYELID & FACIAL PLASTIC SURGERY

Agreement of Financial Responsibility

Thank you for choosing Diana Tamboli MD, LLC as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

•Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

• It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

• Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the InNetwork rate.

• I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Diana Tamboli MD, LLC to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

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We are happy to file any insurance on your behalf, but please be aware that we DO NOT participate in all plans. If you are uncertain if our office participates in your plan, you should call the customer service number listed on the back of your card and ask them directly. Many companies are now offering multiple plans, and some have a closed network. We are not able to confirm or deny our participation with any certainty.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account. This includes wireless telephone numbers which could result in charges to you. We may also contact you by sending text messages or e-mails using any e-mail address you provide us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature: _____ Date: _____