ANDREA TROWERS, M.D.
EASY PAY FORM
Required

If we are a participating provider for your health insurance, we will file insurance claims to your company. However, if a service performed by the doctor is denied, not a covered service or you are found to have a deductible or co-insurance amount, you will be responsible for paying the balance with the Easy Pay Form.

What is the Easy Pay Form? Why is it necessary?

Occasionally you will have deductibles and co-insurance obligations unbeknownst to us that have been set by **your** insurance company, leaving a balance on your bill. We will always warn you if feel a service may not be covered, however, ultimately the insurance contract is between you, your employer and your insurance company.

Andrea Trowers MD PA does not mail invoices or bills to patients for balances.
If we receive notice that there is a balance on your account your payment will be processed with the Easy Pay Form and you will be called to let you know that payment has been processed. We will also mail you a receipt with a copy of your medical insurance statement with your balance. This allows us to obtain quick payment so that we may concentrate on providing you with quality medical care and not be occupied with sending outstanding balances to collection agencies.

Please complete the square below to authorize future payment for any balance which will be an out of pocket expense, **as determined by your insurance company only.** Your billing information will be kept in a **locked** cabinet and be guarded by the same privacy standards use for your medical records.

I authorize ANDREA TROWERS MD PA to keep my signature on file and to charge my credit card for the patient responsibility portion of any balances incurred by me in the calendar year ending in 2007.

I understand that this EASY PAY system will only be implemented in the following cases:
-If a deductible has been applied by my insurance company and was not collected on the day of service.
-If I am not covered by my insurance for the services rendered.
-If a service that has been provided is not covered by my insurance company.

I UNDERSTAND THAT I AM ENTITLED TO A REFUND SHOULD MY INSURANCE COMPANY LATER DECIDE TO PAY FOR THE SERVICE INITIALLY DENIED.

CREDIT CARD ACCOUNT INFORMATION

Please write your credit card number in the boxes above

Expiration Date: _____

Customer Code

Type: Visa Mastercard American Express

Name on Credit Card: _____

***Cardholder'sSignature: _____ Date: _____**