Kenneth J. Galang, M.D., P.A.

FINANCIAL POLICY (2023)

I **authorize financial information and reports** of my evaluation, treatments, and any follow-up evaluations to be sent to or discussed with my referring doctor requesting consultation, my family physician, as well as any other healthcare providers, hospitals or outpatient facilities that I have or will identify to you.

I authorize any holder of medical or other information about me, to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agents of my insurance companies or to my employer if this is a worker's compensation claim, any information needed for this or related insurance or Medicare claim. I permit a copy/fax of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment. If I have been tested for or have contracted Autoimmune Deficiency Syndrome (AIDS)/Human Immunodeficiency (HIV), I authorize the release of the fact and/or results of testing to any of the individuals, healthcare providers or third-party payers related to my care. (This practice does not provide or perform testing for the virus.)

I understand that I am fully and legally responsible for all charges for services rendered which include all outstanding balances not covered by Medicare and/or insurance companies. In the event, I fail to pay any outstanding balance, I also agree to pay all billing fees, collection agency fees, and attorney fees and court costs, if any.

NO SHOW POLICY/LATE CANCELLATION

I understand that I will be charged: **$75.00** if I miss a regular appointment or **$150.00** if I miss an appointment for a procedure **or** fail to cancel at least 24 hours before my scheduled appointment.

AUTHORIZATION POLICY

I understand that I will be charged the amount of **$35.00** for any Prior Authorization Request for Medications that my insurance is requiring for me to get the medication Dr. Kenneth Galang, MD., PA. prescribes. I understand that I will be charged the amount of **$35.00** for any authorizations acquired for procedures if I decide to not to continue with the procedure.

URINE DRUG SCREENING POLICY

I understand I will be charged **$70.00** if my insurance does not pay for or denies the Urine Drug Screening Test done here in the office. I understand our in-office Urine Drug Screening must be done no less than four times a year according to the Florida State Department of Health and Pain Management Statutes.

CONVENIENCE FEE

Credit and debit card payments are subject to an additional, non-refundable **$3.00** charge for every $99.00 charged.

BCBS Grace Period

If you are in the BCBS grace period, I will be charged $285/office visit and $70/UDS. After 5 months my office visit charges may be refunded once we have confirmation of BCBS payments. (The UDS charges are not refundable)

UHC Dual Complete

I understand that Dr. Galang is not a Medicaid provider and will not be taking the UHC Dual Complete at this time.

WE DO NOT ACCEPT PERSONAL CHECKS

Patient Name: ________________________ Date of Birth: _____________ Patient Signature: _________________ Date signed: ____________

Guarantor Name: _____________________ Guarantor Signature: ___________________________ Date signed: _________________________