

KASSAMO DAYEMO, M.D.
Gastroenterology, Board Certified

PAYMENT POLICY

Effective July 1, 2011 our payment policy will be as follows:

- 1.) If your case is a private insurance case, you are responsible for all co-payments and deductibles according to your plan at every visit.
- 2.) If you are a self-paying patient, you are responsible for all the payments prior to seeing the doctor.
- 3.) Please give 24-hour cancellation notice for office visit. \$25.00 fee failure cancellation notice.
- 4.) Please give 72-hour cancellation notice for Procedure. \$100.00 fee failure cancellation notice.
- 5.) Return checks for insufficient funds fee \$35.00
- 6.) Any type of medical forms that needs to be completed by the doctor is \$25.00 up to two pages; additional pages will be \$10.00 per page.
- 7.) As a courtesy, we will file your claims to your Primary and Secondary health insurances.
We **DO NOT ACCEPT THIRD HEALTH INSURANCE.**

I hereby authorize Kassamo Dayemo, MD PA to furnish information to insurance carriers concerning my illness and treatment in order to process claims, and assign to the physician all payments for medical services rendered to me and my dependants. I understand that Kassamo Dayemo, MD PA files all insurances as a courtesy. In addition, I am responsible for any balance NOT covered by my health insurance. Any expenses incurred due to delinquent account involving collection agency and attorney fees will be my responsibility.

If you have any questions or need assistance, please feel free to speak to the accounting office.

Patient Name: _____ Date: _____

Signature: _____