LYLE D. KURTZ, M.D., INC.

Internal Medicine

Patient Agreement

Thank you for choosing our office for your medical care. We are committed to providing you with quality healthcare and ensuring your treatment is successful. The following explains our office policies and your financial responsibilities. Please read it, let us know if you have any questions, and sign below acknowledging acceptance.

1. I consent to all services rendered and authorize my insurance carrier to pay Lyle D. Kurtz, M.D. directly.
2. I understand that it is ***MY RESPONSIBILITY*** to understand what my policy covers and does not cover and knowing what is and is not covered by my insurance plan ***is not*** the responsibility of Dr. Kurtz or his staff.
3. I agree to pay for any services rendered that Dr. Kurtz and I deem medically necessary, even if my insurance company refuses to pay for such services.
4. I authorize release of medical records or any other information necessary to provide health care, process medical claims or any other purposes related to health care operations.
5. I agree to be responsible for any balance due, including balances for out of network services provided, regardless of an insurance company's determination of "usual and customary" rates.
6. I understand that copayments, deductibles and all outstanding balances are due upon receipt. If payment is not received within 30 days, ***my credit card will be charged for the amount due.***
7. I understand that any outstanding balances of over 60 days will be forwarded to a collection agency and/or attorney. In addition to the unpaid balance, I will be responsible for a fee of 33% of the unpaid balance plus any additional fees incurred.
8. I agree to keep Dr. Kurtz' office up-to-date at all times with a copy of the front and back of my most current insurance card. Failure to do so may result in my being personally responsible for any charges.
9. I agree that if my insurance company takes more than sixty days to make payment for a claim *for any reason* not the fault of Dr. Kurtz, I will be responsible for payment of said claim in full.
10. I understand that the office requires a 24-hour cancellation notice. A fee of no less than $75 will be billed for no-show office visits and $175 for physicals, consultations and preoperative visits.
11. I understand that I will be charged a $35 fee or the bank charge, whichever is larger, for any check returned by the bank for any reason.
12. I agree to allow Dr. Kurtz to contact me with results via email. If a different method is preferred, I will notify Dr. Kurtz's office.
13. I will NOT contact Dr. Kurtz via email or texting for any condition that requires an urgent or emergent response. I further understand that it may take up to 72 hours for Dr. Kurtz to respond to an email or text.

By signing below, I affirm that I have read, understand and agree with all of the above. Any questions I have regarding the above have been answered to my satisfaction.

_____ _____

Name Today's Date