



**BILLING POLICY OF DOCTOR KARA, P.C.**

In the rare event that payments or co-payments are not paid in full at the time of service for any reason, the following charges will apply to your account:

1. **I understand that as an insured patient, I am responsible for any administrative fees and all medical charges regardless of decisions made by my insurance plan. Due to the nature of submitting claims to insurance plans and delays in payment, any finance charge and invoicing fee will be retroactive to the date of service.**
2. Insured patients are responsible for providing accurate insurance information at the time of service, including proof of insurance coverage. Any insured patient who fails to submit an insurance card will be treated as a cash pay patient and is subject to cash pay rates of \$3/minute.
3. Invoicing fee in the amount of \$10.00 per invoice to cover postage and time spent generating an invoice.
4. The annual finance charge of 18% will be applied to the unpaid account balance (1.5% per month).
5. Once the unpaid account balance reaches 30 days maturation from the date of service, the account will be turned over to a collection agency, unless special arrangements have been made with Doctor Kara PC for installment payments on overdue balances.
6. In the event legal action is taken to collect on the account, an additional amount of 50% of the principal balance will be added to offset the costs of attorney's fees, court costs, or collection agency actions. This additional amount is in recognition of the costs associated with collection action processing.
7. In the event Doctor Kara, P.C. is unable to obtain a valid payment I agree to pay an additional administrative fee of \$25.00 per occurrence to offset the time and effort spent in notifying me of an invalid payment.
8. All communication and inquiries to Doctor Kara, P.C. about my account must be submitted in writing by the account holder (or executor of the estate in cases of a deceased account holder). Doctor Kara, P.C. will respond in writing within 7 calendar days, except during periods of extended absence. Office closure dates will be posted on the clinic website and the office entrance. I agree to notify the office in writing of any changes in my contact information (name, address, phone number, work number, etc). I hold Doctor Kara, P.C. blameless for lost communication in the event I fail to maintain accurate contact information with the office.
9. The information given in the registration form is valid and true to the best of my knowledge. I understand I am financially responsible for all office charges payable to Doctor Kara, PC. I also authorize Doctor Kara PC to release limited medical information to expedite the process of requesting lab or diagnostic tests and necessary medical referrals to other medical professionals during the course of my treatment.

**APPOINTMENT POLICY OF DOCTOR KARA, P.C.**

We realize that life is full of unexpected events that can cause a patient to be unable to meet a previous obligation. We ask that you make every attempt to let us know something has gone awry. We are committed to every patient having the opportunity to enjoy the unique and exceptional customer service we offer: self scheduling, on-time appointments, and "No Wait" guarantee. These policies help protect our great customer service and patient pricing:

1. Tardiness Clause:
  - I understand I may only be seen for the remaining time of the appointment and may have to schedule a second visit to complete any unfinished business.
  - I understand I will be responsible for the cash-pay rate of \$3/minute for the tardiness and the missed service that may not be paid by insurance, if insurance applies to my case.
  - I understand I may be asked to reschedule for another appointment if tardy by 10 minutes or more.
2. Appointment Fees:
  - I understand that I forfeit my appointment reservation fee for any late cancellation, failure to show for an appointment, or rescheduling of an appointment. The reservation fee offsets the financial loss incurred by Doctor Kara , PC since appointments are not double or triple-booked.
3. Cancellations and rescheduling should handled by calling Doctor Kara, P.C. at 801-495-9303.

**FINANCIAL VERIFICATION STATEMENT**

My signature verifies I understand and validate the following statements:

- I am the authorized cardholder of the credit card listed on the registration page 1.
- I designate the credit card listed on page 1 as the “credit card of record” for my account.
- In the event the credit card of record is reported as lost or stolen, I will provide Doctor Kara, P.C. with new and valid credit card information as the credit card of record to maintain an account in good standing.
- I authorize Doctor Kara, P.C. to make charges against the credit card of record in accordance to the terms and conditions listed in the billing policy, appointment policy, or any other special contracts I hold with Doctor Kara, P.C. (i.e. VIP membership).
- I am responsible for maintaining accurate and valid payment information with Doctor Kara, P.C. to facilitate valid payment for medical services requested and/or received.
- In the event Doctor Kara, P.C. is unable to obtain a valid payment, using the credit card of record, I agree to pay an additional administrative fee of \$25.00 per occurrence to offset the time and effort spent in notifying me of an invalid payment.
- Future terms and conditions may change without prior written notice and will be posted on the Doctor Kara, P.C. website and at the office for general public viewing.
- I acknowledge that if I misrepresent personal and financial facts to Doctor Kara, P.C. in order to obtain medical services under false pretenses or to avoid paying valid charges payable to the clinic, those misrepresentations may be construed as probable fraud. In cases of probable fraud, I can expect Doctor Kara, P.C. to do the following:
  1. file a theft report with the necessary authorities,
  2. provide all available supporting documents and information regarding the fraudulent activity to investigating authorities,
  3. immediate referral to a collection agency for legal action on behalf of Doctor Kara, P.C.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Special Case of Credit Card Use Permitted by the Authorized Cardholder:**

I, \_\_\_\_\_, the authorized cardholder am verifying that  
 (authorized cardholder’s printed name)

\_\_\_\_\_ who is my \_\_\_\_\_ has my  
 (printed name of patient) (relationship to authorized cardholder)

permission to use my credit card as the credit card of record as the form of payment for the account established with Doctor Kara, P.C. until such time that Doctor Kara, P.C. receives **written** notification that said permission is revoked. Doctor Kara, P.C. will confirm in writing the receipt of the written revocation notice and make other account payment arrangements with the patient immediately upon receipt of the revocation notice.

I also verify that I have reviewed the terms and conditions as outlined in this document and clinic website and agree to abide by those terms. Future changes in terms and conditions will be posted on the clinic website and in the office and may be in effect without prior written notice.

Authorized Cardholder’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_