Thomas Susko M.D., Inc.
2021 Santa Monica Blvd #200e
Santa Monica, CA 90404
Phone: (310) 829-5557
Fax: (310) 829-5554

Good Medicine Takes Time

FINANCIAL AGREEMENT

Your signature below forms a binding agreement between Dr. Thomas Susko (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party. The Responsible Party is the individual who is financially responsible for payment of medical bills.

Medical Insurance

We are in-network with United Healthcare PPO, Cigna, and Medicare, and bill them directly for services rendered.
We are out-of-network for all other insurances, but we will gladly submit a claim on your behalf. We will also conduct a benefits investigation before each visit and, based on the summary of benefits response from your insurance, we will collect a payment towards your visit.

As the responsible party, you are responsible if your insurance company declines to pay for any reason, makes a payment directly to you, or if you have a balance due on your account after insurance pays for your visit.

The Patient or the person signing on behalf of the Patient as the Responsible Party must:
• Inform this office of the current address and phone number for the patient and the responsible party.
• Present all current insurance cards prior to each office visit.
• Verify every 6 months that the information is current by signing our data sheet.
• Pay any required copay at the time of the visit, as well as all previous balances due.
• Pay any additional amount owing within 30 days of receiving a statement from our office.
(When the provider receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $35.00 service charge. Once notice is received of the returned check, this office will contact the Responsible Party of the returned check. If a response is not made within 15 days from the date of contact by the Patient or the Responsible Party, the account may be turned over to our collection agency and

a collection fee will be added to the outstanding balance – in addition to the $35.00 Check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient, or the patient's Responsible Party, understands that this office has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

_____

Responsible Party Name (Please Print)

_____ _____

Responsible Party Signature Date