

JOHN D. BRAY, M.D.

PEDIATRIC & ADULT ALLERGY/IMMUNOLOGY
PEDIATRIC PULMONARY DISEASE
SLEEP DISORDERS MEDICINE

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FELLOW
THE AMERICAN ACADEMY OF ALLERGY
& IMMUNOLOGY
THE AMERICAN COLLEGE OF CHEST PHYSICIANS
THE AMERICAN COLLEGE OF ALLERGIES
THE AMERICAN ACADEMY OF PEDIATRICS
THE AMERICAN SLEEP DISORDERS ASSOCIATION

DIPLOMATE
AMERICAN BOARD OF ALLERGY &
IMMUNOLOGY (ADULT & PEDIATRIC)
AMERICAN BOARD OF PEDIATRICS
(GENERAL PEDIATRICS)
AMERICAN BOARD OF PEDIATRICS
(PEDIATRIC PULMONARY)
AMERICAN BOARD OF SLEEP
DISORDERS MEDICINE & CLINICAL
POLYSOMNOGRAPHY (ADULT & PEDIATRIC)

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. WE PROVIDE INSURANCE FORMS TO FILE ON OFFICE VISITS. It is customary to pay for services when rendered unless other arrangements (such as insurance) have been made in advance, and approved by the office manager.

There are a multitude of medical insurance companies and each company may have multiple types of medical policies. We do not and cannot know each individual insurance company's policies in regards to their payment procedure, reasonable and customary limitation, pre-existing clauses, non-covered diagnoses, or non-covered medical procedures. Your individual medical insurance coverage should be thoroughly investigated by you and if a dispute should arise, full payment will still be required in this office and it will be your responsibility to negotiate with your insurance company for reimbursement.

INSTRUCTION TO INSURANCE COMPANIES FROM THE PATIENT:

I EXPRESSLY WANT THE CHECKS SENT TO JOHN D. BRAY, M.D. IF FILED BY HIS OFFICE.

This is an insurance consignment and payment agreement between John D. Bray, M.D. and

I here by authorize Dr. Bray to furnish information to insurance carriers concerning my illness, and treatments. (I AM SPECIFICALLY REQUESTING THAT ANY AND ALL INSURANCE PAYMENTS BE MADE DIRECTLY TO DR. BRAY.) If this payment is sent to me in error, I will immediately endorse the check and forward it to him. I understand that this payment is for services rendered and rightfully belongs to Dr. Bray.

INSURANCE CONSIGNMENT AND PAYMENT AGREEMENT
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I understand that I am responsible for any and all amounts rendered in this office including those not covered by my insurance, and will promptly render the full outstanding balance within 30 days of notification. I understand what is called "reasonable and customary" in today's health care environment usually means that the insurance company has decided to pay. Many times, it has little relationship to what a service is really worth, or what board certified specialist in a particular field are charging around the state. If you have any questions about this point, please ask the receptionist, or office manager. This balance may be paid with cash, check, or credit card. Should any problem arise with a check or credit card payment, I will resolve the matter promptly, if there should be any refund due to the patient, once his/her insurance payments arrives, Dr. Bray's office will promptly refund the proper amount. Any balance, which is the responsibility of the patient, not paid in 61 days of notification, is subject to a 1 ½ % interest charge compounded monthly, until the balance is fully paid.

Dr. Bray's office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. We will also, not become a party to any disputes between separated or divorced parents over a child's bill. BOTH parents will be held responsible for prompt payment.

If I have made arrangements to pay in full, I will be totally responsible for my child's or my charges and no insurance will be filed by Dr. Bray's office personnel as long as I pay my bill in full as services are rendered.

WE STRONGLY ENCOURAGE ALL PATIENTS TO INQUIRE ABOUT THE COST OF ANY ORDERED PROCEDURE, OR THERAPY BEFORE IT IS IMPLEMENTED. WE WILL BE HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

I HAVE CAREFULLY READ AND UNDERSTAND THE ABOVE

DATE: _____ SIGNATURE: _____

WITNESS: _____