FINANCIAL POLICY

ANGELA BULLY, M.D.
TAMMIE L. BULLY, M.D.

Patient Name: _____

Soc Sec Num: _____

Thank you for choosing Dr. Bully as your health care provider. We are committed to your treatment being of the highest quality. As part of the provider/patient relationship, we believe that it important for you to understand the Financial Policy regarding payment for services. We ask that you review and sign this policy prior to any treatment.

Regarding Insurance Coverage

Dr. Bully serves as participating provider with Blue Cross and Blue Shield of Michigan, Medicare and Medicaid, as well as a select group of other insurance companies.

For those companies with whom Dr. Bully does not participate, payment for services at the time of your visit is your responsibility. **Please confirm whether your insurance is accepted before being seen.**

The balance of all visits/treatment is your responsibility whether your insurance company pays or not. In order to bill your insurance it is necessary for you to bring all insurance information. As a courtesy, we will bill your insurance company. If your insurance company has not paid your account in full within 90 days, we will contact you regarding recovery of the amount owed.

If your insurance coverage is with an HMO or other Managed Care Program, we will bill them for you only if you present an authorization for services from them. You are still responsible for payment of deductibles, co-pays, and non-covered services. If you do not have an authorization for each visit and /or treatment, the responsibility for payment will be yours and must be paid at the time of service.

Adult Patients

Adult patients are responsible for the entire amount not covered by insurance.

Minors

The parent(s) or guardian(s) of a minor will be responsible for entire amount not covered by insurance.

Credit Risk

I understand that should I default on payment for services, then my account may be transferred to an independent collection agency, designated as a CREDIT RISK and that payment for services at the time of registration will be required for all future visits.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

X_____ DATE: _____
Signature – Patient / Responsible Party

X_____ DATE: _____
Signature – Co-Responsible Party

Please let us know if you have any questions or concerns