Andrea Nomberg MD Family Medicine

Collection of deductible/ Coinsurance Form

Patient name_____

Insurance Plan_____ID#_____

Patient Mailing Address:_____

City_____ State_____Zip code _____

Dear patient,

We will verify with your insurance carrier whether or not your insurance coverage indicates a deductible balance. You are responsible for paying for services that fall under deductible/coinsurance.

As a participating provider, Dr. Andrea Nomberg will submit the claim on my behalf for services rendered, directly to my insurance carrier. Upon receipt of my Explanation of Benifits from my insurance carrier, I understand that i am responsible for any applicable deductible/coinsurance and I must provide payment directly to my provider within 30 days. I have agreed to pay for any applicable deductible/coinsurance. If I do not pay in 30 days, I understand that my provider may seek alternative methods to collect these monies.

I Understand that I am responsible fo paying my provider directly for any applicable deductible/coinsurance/co-payment. This is mandatory requirement when receiving healthcare services. I understand that if I do Not fulfill this requirement, my provider may notify my insurance carrier, and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I also understandthat if I have longstanding unpaid deductiblescoinsurance/copayment owed to my provider, my provider may terminate the doctor/patient relationship as a result, subject to the requirments of state and/or federal law.

I further understand that if my provider collects any applicable deductible/coinsurance from me and is also reimbursed directly from my insurance carrier, that wil be reibursed from my provider and overpayment owed to me, no later than 45 days after the provoders receipt of insurance carrier notification.

Patient/guardian signature:_____

Date: _____