Sanjeev Kohli M.D., PC

Ph: 703-492-6726 Fax: 703-492-2400

2200 Opitz Blvd,Ste335
Woodbridge, VA 22191

Office Policy Information Sheet

www.drsanjeevkohli.com

Appointments: In scheduling appointments, it is our intent to see you as soon as possible, given the constraints of our mutual schedules. Our staff will offer you the first available appointment, and will ask you some basic questions. Our staff will make every effort to accommodate requests. We will make every effort to see you on time at your scheduled visit, however, to avoid delaying other patients; individuals arriving early for their appointments may not be taken until the scheduled time. Please be aware that emergencies do arise which might delay your scheduled appointment. You will receive a call reminding you of your appointment time. Please call us back if you need to change the time of your appointment to avoid any missed appointment charges

Prescription Refills: All Prescription refills will be processes within 24 hours. Please make sure that during your office visit, you have all prescriptions refills until next office visits. No refills will be call in to your pharmacy. If you do not have medications you have to make appointment to see the doctor and receive prescriptions

Clinical Phone Calls: To avoid disrupting daily patient flow, please choose the phone option and follow the instructions for a return call from a nurse. Please indicate where you may be reached during the day or whether we have permission to leave a message at the number provided. Messages are retrieved throughout the business day. Urgent requests are handled as soon as possible. All other calls requiring follow up will be returned before the end of the next business day.

Test Results: Results are generally received in our office within 7-10 days after tests have been performed. Our providers review all reports and you will be notified of the results.

Referrals: For those plans requiring referrals to specialty physicians, you must first receive authorization from your provider who is your designated primary care provider (PCP). To request a referral, please call the office at 703-492-6726. If you have not been seen by your treating provider within the past six (6) months for the condition necessitating the referral, you will need to schedule an office visit prior to receiving the referral

Medical Records: Original records are the property of the Practice and will not be released. Per federal regulations, we require a signed Release of Medical Records form prior to processing of requests. Medical records will not be faxed. Pursuant to Virginia Code subsection B of 8.01-413, there will be charges surrounding duplication of records in the amount of $0.50 per page for up to 50 pages and $0.25 per page thereafter, plus all postage/shipping costs, and an administrative fee of $10.00. We require payment in advance. Processing will be completed within 15 days from the date we receive your signed authorization and payment. Urgent requests will be treated as such.

Financial Policies: All outstanding balance after 90 days will be forwarded to collections agency automatically and incur a 25% collection fee. Patients at collections cannot be seen until account is fully paid. We request you to respond to initial statements and pay your account balance or contact our patient accounts department at 1 800 893 3557 to set up payment arrangements. Once your account has been sent to collections agency, office staff will not be able to help you and now you have to speak with collection agency staff

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Billing Inquiries - Please call 703-492-6726 for all billing questions. Our staff makes every attempt to assist you at the time of your call. To facilitate their efforts, please have the necessary information available that you wish to discuss

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Capital Area Internal Medicine for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. If other health insurance: is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

YOUR INSURANCE: We will be happy to bill your insurance carrier for you. Please note that we **do not take assignment on auto-related claims** or insurance carriers that we do not participate in. If your insurance requires a referral, it is **required** that **you have your referral with you at the time of service. It is your responsibility to ensure that your referral is current**. Co-payments/co-insurance is due at the time of service. In the event your health plan determines a service to be "not covered" or it has been over sixty (45) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and **payment is due upon receipt of that statement.**

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

Minor Patients: For all services rendered to minor patients, the adult accompanying the patient is responsible for payment

Cancelation: We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a $25 charge.

RETURNED CHECKS: It is our office policy to charge a fee of **$25.00 for any returned checks.**

COMPLETION OF FORMS: We will be happy to complete attending physician's statement, insurance and disability forms for our patients. The patient is responsible for payment of any fee prior to completion of the forms**. Please allow 10-14 business days for completion of forms.**

DELINQENT ACCOUNTS: We reserve the right to add reasonable interest and collection charges to any account over 90 days past due. Interest of 1.5% would be added on (for each month) if the bill is not paid within 90 days.

DECLARATION: I have read and I understand the financial and Office policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____
SIGNATURE & NAME of patient / insured / guarantor / responsible party DATE

_____ _____
SIGNATURE & NAME of Co-Responsible Party DATE