



Affiliated Physician
MDVIP

Viraj V. Tirmal, MD
Internal Medicine

Viraj V. Tirmal, MD LLC

INFORMED CONSENT, FINANCIAL POLICY/INSURANCE, ASSIGNMENT OF BENEFITS

Viraj V Tirmal MD LLC

Consent for Treatment: I have a general understanding of the treatment, the medically acceptable alternative treatments including not receiving any treatment, and the substantial risks and hazards inherent in the treatment. I am aware that there no guarantees about the treatment. I have informed the doctor of all of my allergies, medications including over-the-counter, supplements, herbal therapies, aspirin, and alcohol or recreational drug use. The doctor has answered all of my questions. I authorize the doctors of Viraj V Tirmal MD LLC to provide treatment to me or my dependent.

Financial Policy: I understand that I must provide Viraj V Tirmal MD LLC with my insurance card, along with a photo ID at each visit and as a courtesy to me, Viraj V Tirmal MD LLC will file a claim to my insurance company with the insurance information I have provided. I understand it is my responsibility to advise Viraj V Tirmal MD LLC of any changes in my insurance coverage and benefits. I accept responsibility for the remainder of charges that are not fully reimbursed by my insurance company or for amounts deemed my responsibility by my insurance company. I understand that payment of these amounts will be due upon receipt of a billing statement. If incorrect or incomplete insurance information was given at the time of service, I will be responsible for the full charges incurred and realize it is my responsibility to contact my insurance company to resolve the issue. Co-payments, deductibles, and outstanding balances are due prior to time of service; otherwise, I understand the appointment will be rescheduled. I understand that if no insurance is to be billed, payment in full is expected at the time services are rendered. Insufficient Funds: Returned checks will have a \$25.00 check fee added and must be paid prior to any pending appointments. Non-Payment of Services: In the event that it is necessary for my account to be sent to an outside collection agency, I understand that I will be responsible for any collection fees including legal fees and costs. In addition, I understand that I will be discharged from the practice along with all family members. Any further contact or correspondence regarding the account, will be handled by the outside collection agency.

Assignment of Benefits: I authorize insurance benefits, otherwise payable to me by my insurance company, to be paid directly to Viraj V Tirmal MD LLC for all professional services furnished. I irrevocably assign to Viraj V Tirmal MD LLC the rights and benefits and all causes of action resulting from any reduction and/or nonpayment under any policy of insurance for any services provided by Viraj V Tirmal MD LLC. I authorize any holder of medical information about me to release to my insurance company, the Center for Medicare and Medicaid Services, or any agent for these entities any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to Viraj V Tirmal MD LLC in applying for payment by my insurance or under the Medicare or Medicaid program is accurate and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Name of Patient or Patient’s Representative

Signature of Patient or Patient’s Representative

Date

Relationship to Patient

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