

# ***PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.***

1515 N. Flagler Drive, Suite 430 • West Palm Beach, FL 33401  
6056 Boynton Beach Blvd, Suite 245 • Boynton Beach, FL 33437  
550 Heritage Drive, Suite 150 • Jupiter, FL 33458  
1041 State Road 7, Suite 1 • Wellington, FL 33414  
**Telephone Number (561) 659-6336 Fax Number (561) 659-9353**

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William A. Kaye, M.D., F.A.C.P.  
Barry S. Horowitz, M.D., F.A.C.P.  
Shital R. Patel, M.D.  
Kathryn Reynolds, M.D.  
Geetanjali K. Kale, M.D., M.B.B.S.  
Leslie Cotto, M.D.  
Morolake Amole, M.D.  
Alexis da Silva, M.D.

Marcela Bustamante, M.D.  
Mayra Romina Lomonaco, M.D.  
Natalia Viera-Feliciano, M.D.  
Charles Chaboude, M.S.N. APRN  
Julia A. Lindower, M.S.N. APRN  
Stephanie Devaney, MSN APRN, FNP-C  
Carol Kreider, M.S.N. APRN, FNP-C

## **Patient Financial Policy Sheet**

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Discover, Mastercard, American Express, and Visa.

### **Your Insurance:**

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment, co-insurance, or deductible at the time of service. This office's policy is to collect when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

### **Minor Patients:**

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

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

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Printed Name of the Patient

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Signature of Patient or Responsible party if a Minor

Date \_\_\_\_\_