Duraid Ahad-Daman, MD
1380 Coolidge Hwy, Suite 250
Troy, MI 48084

Insurance Office Policy

On arrival, please sign in the front desk and present your CURRENT insurance and picture ID. We will file your insurance claim as a courtesy to you. It is your responsibility to provide us with the correct insurance information. If you have a secondary insurance coverage, you will need to present that insurance at the same time

We do not make any guarantees regarding the payment of your insurance claims. It is your responsibility to understand your benefits plan. It is also your responsibility know if a written referral or authorization is required for you medical care, if per-authorization is required prior to procedure, and what services are covered. Not all services provided by our office are covered by every plan. Any service determined not to be covered by your plan will be your responsibility.

You are responsible for all co-payments, deductibles, and coinsurance. Once your insurance carrier has processed your insurance claim. You are responsible for any remaining balance on your account.

For scheduled appointments, prior balance must be paid prior to visit. If you have no insurance, payment for office visit is t be paid at the time of the visit.

Co-payments are due at the time of service. Patient balance are billed immediately based on insurance plan benefits. A fee of $25 will be charged on any checks returned due to insufficient funds. All unpaid balances are billed monthly. Payment is due within 30 days of billing. Payment will be requested for unpaid balances more than 90 days old, and unpaid will be referred to agency. Finance charges will apply. If an account in is collection, the patient must pay for all current services at the time of appointment including the delinquent amount before seeing the doctor.

Medical Record Policy

If medical records or FMLA papers are requested, you will be charged a fee up front and it will take 72 hours or longer to process and complete your request.

No Show Policy

We charge a **$25 missed appointment fee** if you do not contact the office within 24 hours to cancel or reschedule, which must be paid for prior to next scheduled appointment. Unless there are extenuating circumstances, after a third “No Show” appointment you will receive a letter stating that you are being discharged from the practice.

Name (printed):_____ Date:_____

Signature (Patient/ Legal Guardian): _____