

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH AND CHECKS.

Regarding Insurance

We may accept assignment of insurance benefits after your second visit. However, we do require 50% of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider, all co-pays, co-insurances and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

If your policy requires a referral and is not provided by the time of your first appointment, you will be charged the full cost of the visit.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, payment by cash or check at the time of service has been verified.

Cash patients (Please initial this paragraph)

You will be considered a cash patient only if you have no insurance coverage. If your status changes notify our office immediately X _____

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$25. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this policy.

X _____
Signature of Patient or Responsible Party

Date _____

X _____
Signature of Co-Responsible Party

Date _____