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Financial Policy

Thank you for choosing my office. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. I require you read and sign this agreement before beginning any treatment. PAYMENT IS DUE AT TIME OF SERVICE. I ACCEPT CASH, CHECKS, AND MOST CREDIT AND DEBIT CARDS.

Regarding Insurance

If I am a *participating provider* with your insurance **("contracted insurance")** I will collect your co-pays, deductibles and non-covered supplies at the time of service. It is your responsibility to make sure your insurance company pays within their contracted period (30 days from date-of-service).

- **HMO PATIENTS:** It is your responsibility to obtain the appropriate referrals prior to your visit, or I will have to collect payment at time of service.
- **ASSIGNMENT OF BENEFITS:** In the event I am a participating provider with your insurance I will accept payment from your insurance. Your signature below authorizes this action; you will be billed once your insurance has responded, if you legally owe more. If I am not contracted with your insurance **("non-participating")**, I expect payment at the time of service. I can usually offer a discount for full payment at time of service as well
- **MEDICARE PATIENTS:** I accept assignment from MEDICARE and will submit to Medicare on your behalf. Medicare will reimburse for allowed charges, if you have met your deductible and submit to your secondary insurance. You may be responsible for a portion of the fees after payment by Medicare, depending on your plan.
- **MINOR PATIENTS:** The adult accompanying a minor is responsible for full payment at time of service.
- **ASSIGNMENT OF BENEFITS:** If I do agree to accept payment from your non-contracted insurance, I require a credit card authorization for any balance due. Should your insurance not pay within 45 days, the entire balance will be transferred to the credit card number on file

PATIENT RESPONSIBILITY

Patients are responsible for their insurance CO-PAYS, DEDUCTIBLES, CO-INSURANCE, and all NON-COVERED ITEMS at time of service, if applicable.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, my policy is to charge for missed appointments at the rate of a normal office visit. Your insurance will not be charged for the missed appointment and you will be responsible. In the case of Worker's Compensation and Medicare patients no fee will be charged.

COLLECTION OF AN OUTSTANDING BALANCE

Payment is due at the time of service, or within 30 days of being billed. If I need to send more than one (1) statement, an EIGHT dollar ($8.00) billing fee will be added to your account. If your account should become past due and every reasonable attempt has been made on our part to collect the debt, your account may be sent to collections. Reasonable collection costs will be added to each account. You may also be responsible for legal and attorney fees.

I have read the financial policy above and understand and agree to these arrangements.

Patient Name (printed) Signature of Responsible Party

Date