

PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

\*As our patient, **you are responsible for all authorizations/referrals** needed to seek treatment with our practice. **You are responsible for informing our office at the time of check in of all insurance changes and authorization/referral requirements.** In the event the office is not informed, you will be responsible for any charges denied.

\*Unless other arrangements have been made prior to your appointment, or your health insurance carrier, payment for services rendered are due at the time of service. We accept cash, check or credit/debit cards.

\*Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance does not pay our practice within a reasonable period, we will have to look to you for payment.

\*We have made prior arrangements with certain insurers and health plans to accept an assignment of benefit. We will bill those plans with which we have an agreement and will only require you to pay the copay/coinsurance/deductible at the time of service. **Please note EACH TIME you have an appointment with our office you are responsible for paying your copay/coinsurance/deductible at the time of service.**

\*If you have insurance coverage with a plan which we do not have a prior agreement, we will prepare and send the claim for you. You will be responsible to pay your coinsurance/deductible at the time services are rendered.

\*All health plans are not the same and do not cover the same services and/or items. In the event your health plan determines a service or item to be “non covered”, or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges for any services rendered or items received. Patients are encouraged to contact their plans for clarification of benefits prior to services being rendered.

\*Past due accounts are subject to collection proceedings. All cost incurred including, but not limited to, collection fees, attorney fees and court cost shall be your responsibility in addition to the balance due this office.

\*There is a service fee of $30.00 for any returned checks. You are responsible for this amount on top of your balance due.

\*There will be a charge of $10.00 for copies of medical records and/or x-rays.

\*There will be a charge of $10.00 for each form you ask our practice to complete for you.

Signature of Patient/Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient/Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Updated 01/2017