FINANCIAL POLICY/AGREEMENT

Thank you, for choosing us as your health care provider. The following is a statement of our Financial Policy, Which we require you to read, and sign prior to any treatment.

PAYMENT OF DEDUCTIBLE, CO-PAYMENTS, AND ANY UNCOVERED SERVICES ARE DUE AT TIME OF SERVICE. ON MINOR CHILDREN, WHICHEVER PARENT BRINGS THAT CHILD IN FOR SERVICES WILL BE RESPONSIBLE FOR THE BILL/CO-PAY.

NON-INSURED PATIENTS ARE EXPECTED TO PAY IN FULL AT TIME OF SERVICES.

WE ACCEPT CASH, CHECK, OR CREDIT CARDS.

It is your responsibility to provide the receptionist with your most current vital information. You will need to provide a copy of your insurance card upon each visit, and notify us immediately if any of the information changes.

Insurance Policy:

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you we are happy to file your insurance for you. However, you are responsible for paying all co-payments, deductibles, and non-covered services. We are not a party to the contract between the patient and their insurance company we have our own contractual obligations with each of our participating insurance companies.

In the event of assignment of benefits, you are still ultimately responsible for all charges. If your insurance company has not paid your account in full within 45 days, you will be responsible for paying the balance.

Medicare policy:

We accept Medicare assignment on all Medicare claims. This means that we will reduce our fee to the amount allowed by Medicare. We will file one (1) secondary claim for you. You must provide us with the current and correct information at the time of your visit. If you have more than one (1) secondary insurance, you will have to file it yourself. If you ask us to perform a procedure that we believe Medicare will not approve, you will be required to sign an ABN (Advance Beneficiary Notice). Medicare requires this form be signed prior to you receiving the service. You will be required to pay the cost of the non-covered service at the time 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.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. We are committed to your treatment being successful.

Collections Policy:

In the event of nonpayment on your account our office reserves the right to turn your account over to a collection agency/attorney in order to obtain payment.

I have read, understand, and agree to the Financial Policy guidelines.

Patient Signature: ______________________________________ Date: ____/____/______