PATIENT FINANCIAL POLICY

Your understanding of our financial policy 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 in our office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MASTERCARD, DISCOVER, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- We will bill our insurance company as a courtesy to you. All copays are due at the time of your visit. If you have an unmet deductible we pre-collect 60% of the charges incurred that your insurance will apply towards your deductible. If you have a secondary insurance company, we will bill them one time. If your secondary insurance does not pay the balance due within 45 days, the balance will be billed to you and due at that time.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not 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 or referrals; however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plains for clarification of benefits prior to services being rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to collections fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- Balances/Collection Fees: If balances are not paid within 14 days from the statement date a $12.00 rebilling fee will be added to each additional statement sent for the unpaid balance. A consistent attempt will be made to collect outstanding account balances. Past due accounts, more than 90 days, will be turned over to our collection agency and a 35% fee balance due will be added to cover collection costs.
- A 24 hour notice is requested for cancellations of appointments. If you fail to show for an appointment you personally may be charged $50.00, late cancel $40.00 and for a surgical procedure $75.00.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- If your insurance plan has a high deductible, our office requires 60% of our charge at the time of check in; we will also need a credit card. Your credit card number will be held in a secure area. You will be notified in advance that we will be using your credit card.

Signature of Patient/Responsible Party: ______________________________

Printed Name of Patient/Responsible Party ______________________________ Dated__________

________ Patient initials to indicate copy received.