



**F I N A N C I A L P O L I C Y**

Please read the following information regarding our financial policies. Your clear understanding of these policies are important to our professional relationship. Please understand that payment for services and materials are a part of that relationship. Payment is expected at the time of service unless other arrangements have been made.

**INSURANCE CLAIMS:** Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we can estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

**CO-PAYS:** The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

**SELF-PAY:** We allow for an administrative discount toward services rendered for patients without insurance. This discount is only available if you pay in-full at the time of service. Please ask us for the details of this administrative discount.

**OUTSTANDING BALANCES:** It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

**Returned Checks:** The charge for a returned check is \$35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

**MISSED APPOINTMENTS:** We require 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a fee of \$50.00. Excessive missed appointments and short-notice reschedules may lead to discharge from the practice.

**ACKNOWLEDGEMENT OF RECEIPT**

To be filled out by patient, or responsible party if a minor.

DATE \_\_\_\_\_ PRINTED NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_