Financial Policy/Cancellation Policy

Thank you for choosing us as your healthcare provider. We are committed to you and your healthcare needs. Please understand that payment of your bills is considered part of your care. The following is a statement of our financial policy. We require that all of our patients read and sign it prior to treatment or consultation.

All patients must complete our information and provide insurance information before seeing the doctor/provider**.**
PAYMENT IN FULL IS DUE (UPON REQUEST) AT THE TIME OF SERVICE.
For your convenience, we accept Cash, Credit or Debit cards.

(Please initial after each number.)

1. _____ It is the responsibility of the patient to confirm that the physician/provider is participating with the insurance plan and that your benefits are active. Our office will file claims to your insurance company for professional services rendered. We cannot bill your insurance carrier unless you give us your current insurance information. Please remember, **INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY.** Benefits may differ depending upon what type of contract you have with the carrier. If your insurance company has not paid your account in full at the end of 90 days, the balance will automatically be transferred to your responsibility for payment in full. Please be aware that some or perhaps all the services provided may be non-covered services and not considered necessary under the Medicare Program or other medical insurances.

2. _____ All **co-pays and deductibles are due at the time of treatment**. We require payment in full for your portion (coinsurance, deductible or out-of-pocket fees) at the time of service. In office we accept Visa, MasterCard, Discover, American Express and cash. If a check is returned from your bank, there will be a **$40** returned check fee added to your total amount due. Ultimately, you are responsible for all charges incurred in our office. The insurance contractual obligation does not allow us to write off co-pays or deductible amounts.

3. _____ If the patient cannot keep the scheduled appointment, **it is the patient's responsibility to give our office at least 24 hours cancellation notice.** We reserve the right to charge an **$85.00** fee for missed or cancelled appointments with less than 24 hours notice. Please help us serve you and other patients better by keeping scheduled appointments.

4. _____ If you are turned over to a collections agency, there will be a **$50.00** processing/filing fee, as well as a fee of **40%** of your balance added to your account that you will be responsible for.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPOSIBILITY AS DESCRIBED ABOVE.

_____ DOB:_____/_____/_____
Patient, Legal Guardian or Responsible Party Signature

Today's Date: _____/_____/20__

Revised 10/18