OUR FINANCIAL POLICY

Please READ and Sign Below

Thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you. Our office and physicians make a great effort to get insurance companies to pay their share in a timely manner, but in order for us to continue to accept our current list of accepted insurance companies, we find ourselves having to make the following decisions: We have implemented this Financial Policy, which we require you to read, agree to, and sign prior to any treatment. If you have any questions or feel you cannot comply with these policies, please ask to speak with the Office Manager.

PATIENT PAYMENTS

Payment (co-payment or co-insurance) is due at the time of service. If you have an outstanding balance, we must collect it before seeing the doctor. You may use cash, check, or a credit/debit card to pay your account.
A current credit card will be kept on file. Please give your credit card to the front office staff to scan into your file with this form. The credit card will be scanned into your secured patient file. Your credit card will be used to cover any services you receive that your insurance company does not cover, including no-show fees.

INSURANCE PAYMENTS

Your insurance policy is a contract between **you and your insurance company**. We are not a party to that contract. We require certain co-payment or prepayment amounts depending on the type of insurance and insurance carrier. If we file your insurance, and the claim has not been paid for any reason within 60 days from the date of service, we require that you pay the balance using one of the approved payments methods, without exception. **If you have not contacted our office within 60 days of receipt of your statement to dispute charges in error or discuss the outstanding balance, you will be held responsible for any charges not covered by your insurance and you will be sent to collections.** We would be more than happy to set up a payment plan, if needed. In the event that your insurance pays us after that time, you will be reimbursed. **After 90 days, your credit card will be charged for the full amount owed. If declined, your account will be frozen.**

INSURANCE COVERAGE

While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by *your* insurance is correct. It is your responsibility alone to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. In addition, be aware that some and perhaps all of the services provided may be non-covered services by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.
Finally, in the event you provide incorrect insurance information that delays payment, **you will be asked to pay full billed charges and seek reimbursement from your insurance provider directly.**

THIRD PARTY PAYORS

OUR OFFICES DOES NOT BILL THIRD PARTY PAYORS. For example, **no car accident claims, worker's compensation, etc.** If you wish to see our doctors for a visit that would normally require us to bill a third party payor, you are required to pay for the visit and/or labs in full as a self-pay patient.

MISSED/LATE CANCELLED APPOINTMENTS

We require 24 hours notice for cancelled appointments. This courtesy will allow others to be seen in a timely manner. The appointment can only be held for **10 minutes** past the scheduled time. If you are not able to make it within these 10 minutes, your appointment will be cancelled and will need to be rescheduled. **If your appointment is cancelled less than 24 hours before the scheduled time or you do not show up for the appointment, a NO-SHOW fee will be applied to your account as follows:**

1st Missed Appointment $35.00 • 2nd Missed Appointment $70.00 • 3rd Missed Appointment $100.00
After the 3rd No Show, you will be discharged from the practice.

You will not be able to schedule another appointment until the no-show fee is paid.

We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak with the Office Manager if you have any questions, comments, or concerns. We thank you for your support, and look forward to serving you in the future.

PATIENT AURTHORIZATION

I have read, understand and agree to abide by the terms stipulated above.

Patient's Signature: _____Date:_____

Revised 8/16/2013