

FINANCIAL POLICY

We are committed to providing the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your responsibility toward your bill.

For our insured patients, we will do our best to verify that your plan covers the services you have requested, however any answers we may get from your insurance company are not a guarantee of payment, and all insurance companies tell us this when we inquire about coverage and benefits. We will bill your insurance company for "covered" services, however, co-payments, co-insurances, and deductibles are your responsibility. Co-payments are expected at the time of service, and any charges applied to deductibles, co-insurance, or cost-sharing will be billed to you. *Any services you elect to receive that are not paid by your insurance company are your responsibility and you will be billed for them.*

Once charges have been applied to a deductible, co-insurance or cost-share, you will have ninety (90) days to pay without finance charges. Any balance older than ninety (90) days will be subject to a 1.5% finance charge per month. Inactive or delinquent accounts will prevent future access to our services until payment is received.

If you have no insurance or are self-pay, full payment is required on the day we provide your care. Our fees are available at check-in so you can decide whether or not you would like to receive the service. *If you are a self-pay patient and elect to receive services, you will need to pay for them on the day you receive them.*

For your convenience, our office accepts cash, checks, credit and debit cards. Returned checks are subject to a \$25.00 service charge and may terminate your privilege to pay by check at future visits.

We understand that full payment can sometimes be a financial hardship. If you are in need of special payment arrangements, we'll can set up a payment schedule with you.

Informing our patients about our financial policy helps us provide the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please contact our office.

I have read and understand the above financial policy. I guarantee timely payment of all charges incurred for the account of the patient below. I further agree to pay any attorney's fees, court costs, and related collection fees incurred in the event that any outstanding balance has to be referred to a collecting agent or attorney for recovery of the fees.

PATIENT NAME: _____
(Printed Name) Signature Date

RESPONSIBLE PARTY'S NAME: (Parent or Guardian of patient under age 18)

(Printed Name) Signature Date