# FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Always bring your current health insurance card to the office.
2. Please notify us at time of check-in of any changes in insurance, address, phone number, etc.
3. Payment is due at the time of service.
4. In an attempt to keep Administrative Costs at a minimum we are requesting payment of your copay, deductible, and/or refraction fee today. If you are unable to pay these today your account may be charged a billing fee of $20.
5. Please make sure prior to your visit that you have all referrals and/or authorizations required by your insurance company for the visit.
6. Please make sure to verify with your insurance plan as to the participation status of the physician you are seeing. We will not deny care to any patient due to uncertainty as to participation status of our physicians with your insurance plan. However, if your physician is not part of your plan your portion of the fees will most likely be higher. Ultimate responsibility for payment of all fees is yours
7. Keep in mind that your insurance policy is basically a contract between you and your insurance company. **We will file all insurance claims for you: however, the ultimate responsibility for payment is yours.**
8. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
9. ***As a courtesy to all scheduled patients, we ask that you give adequate notice (at least 24 hours) if you are unable to make a scheduled appointment. Those who do not give notice may be billed for the missed appointment.***
10. **I understand that I am responsible to pay for all services rendered, including collection fees, attorney fees up to and including court cost in the event of default.**
11. Return Check Fee $20.

Printed Name of Patient ______________________________

Signature of Patient (or legal guardian) ______________________ Date: ______________

Staff Member ______________________________ Date: ______________