

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, all co-pays and deductibles are due at the time of your visit. Additional financial responsibility maybe determined after your insurance has processed your claim. For your convenience we accept [Visa, MasterCard, Discover, American Express, checks & Cash]. NSF checks will incur a \$25.00 fee which will be added to your account balance.

Patient Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This office's policy is to collect this co-payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health 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.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment. All patient under the age of 18 will not be seen without a parent or guardian present/or without a signed consent form.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient

Signature of Patient or Responsible Party if a Minor

Date