

Financial Policy

Patient Name _____ DOB _____

Thank you for choosing us as your health care providers. The following is a statement of our financial policy, which we require you to read and sign prior to treatment. All patients must complete our patient information form before seeing the doctor.

REGARDING INSURANCE

We accept assignment of insurance benefits at the time of service. We cannot bill your insurance unless you bring all your insurance information (i.e. your insurance card and the correct address to bill claims). Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to know your coverage pertaining to deductibles, co-pays, and if we are listed as providers for your particular health plan. If your insurance company has not paid your account in full within 120 days, the balance will automatically be transferred to your name unless previous arrangements have been made with our billing company. Please be aware some, and perhaps all, services provided may be non-covered services and not covered under Medicare and/or your medical insurance.

Please understand that we file primary insurance claims as a courtesy for you, our patient. If you have a supplemental or secondary insurance plan, we will be happy to give you a receipt for your services but you will be solely responsible for billing your secondary insurance.

All patients are responsible for payment (this includes co-pay and deductibles) at the time of service. The adult accompanying a MINOR is responsible for payment in full. Minor patients not accompanied by an adult may be denied services (except in the case of emergencies) unless prior written approval has been given for those services.

Thank you for your understanding. Please let us know if you have any questions or concerns.

I HAVE READ THE ABOVE POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY MY HEALTH CARE PROVIDER. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY (MEDICARE AND/OR ANY OTHER INSURANCE) FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENEFITS TO MY HEALTH CARE PROVIDER.

I FURTHER AGREE TO PAY ALL COLLECTION COST, ATTORNEY FEES, AND OTHER COLLECTION COST THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNT OUTSTANDING.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Signature _____ Date _____