PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between patients and the staff, we have adopted the following financial policy. If you have any questions about the policy, 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.

We require a 24 hour cancellation notice, especially if we have scheduled a procedure for you. Failure to let us know within 24 hours may result in a $25.00 service fee.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we will accept VISA and MasterCard.

As a courtesy, if you have a service preformed other than an office visit, we will file your insurance claim for you if you assign the benefits to the doctor – in other words, you agree to have your insurance company pay the doctor directly. If your insurance does not pay the practice within a reasonable length of time we will look to you for payment.

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for whom we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment when you arrive for your appointment.

If your insurance company requires a referral from your primary care physician, it is recommended that you call your primary physician at least 7 days in advance so that your referral is in the office before you arrive for your appointment. If the referral is not here we have been advised from the insurance companies that we cannot see the patient unless the patient signs a waiver stating that he or she will be responsible for the bill. In that situation, payment will be expected at the time of service.

All health plans are not the same and do not cover the same services. In the event 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.

For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of statement from our office.

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 such terms may be amended from time to time by the practice.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parents or guardian with custody for payment.

In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.

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Signature of Responsible Party Date

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Please Print the Name of the Responsible Party