OUR FINANCIAL POLICY

Thank you for choosing me as your health care provider. I am committed to the success of your treatment. Please understand that timely payment on your bill is a part of the process. The following is my Financial Policy. I require that you read and sign.

Co-Pays for office calls must be paid at the time of visit. I accept cash, checks, money orders, debit and credit cards. Completion of any forms when not at the time of the office visit will be charged an administrative fee of $25.00 CASH.

INSURANCE CLAIM FILING

We will submit all charges to all insurance (Primary, secondary) as a courtesy to you. **We do require all deductibles and co-pays to be paid at the time of service.** We cannot bill your insurance unless you bring all insurance information with you. Copies of your insurance information will be made for our files. If change in policy occurs, it is **your responsibility** to update ALL family members' policy information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. **If your insurance company or companies have not paid your account in full within 60 days, the balance may be automatically transferred to a personal balance due from you.** Please be aware that some services provided may be considered "non-covered" under the terms of your contract and, therefore, not paid by insurance. We accept assignment with Medicare. You are responsible for the payment of your deductible and any co-pays. We also participate in many Managed Care Organizations and will comply with those contractual obligations.

URC (USUAL AND CUSTOMARY RATES) AND MANAGED CARE PARTICIPATION

My practice is committed to providing the best treatment possible for my patients and I feel that my fees are reasonable for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Unfortunately, each insurance company determines its own schedule of fees and they often vary widely. We will provide any information to the insurance company to assist them in determining the proper payment. **If your managed care company requires a referral from your primary care provider, it is your obligation to notify our office if that insurance requires a referral.** Should you need a referral, you need to notify the office at least one week prior to and we will assist you in pre-certification, prior authorization and follow-up care.

NEW PATIENT APPOINTMENTS

Our staff will be calling to confirm your appointment the week before your scheduled appointment day and time. If we should need to leave a message, we **EXPECT** you to call our office back within 48 hours of the date we called you. Failure to do so, we **WILL** cancel your appointment.

NO SHOW POLICY

If you fail to show for a scheduled appointment or to cancel within the **24** hour time frame you will be charges as stated below. You must call and either leave a message on the answering machine **24 hours in advance** or speak with the receptionist for the visit to be considered cancelled or rescheduled.

All appointments New or Established Patient appointments require a 24 hour notice. Penalties are as follows:
New Patient $75 (40 Minutes) Regular visits $25 (10Minutes) Routine, Physical or Procedure visits (20-30 Minutes) $50.

IF YOU HAVE NO INSURANCE

We have multiple payment options available to those patients who do not have insurance. It is very important that payments are timely and consistent. Please ask to speak with the billing department for more details about these programs.

Adult patients: Adult patients are responsible for full payment of their accounts.

Minor patients: Patients under the age of eighteen (18) will **not** be seen unless accompanied by a guardian or signed authorization from that guardian allowing our physician to provide medial treatment. The adult, parent, or guardian accompanying the minor will be responsible for full payment of the account.

Thank you for reviewing our financial policy.

My signature indicates that I understand and agree to comply with this financial policy.

_____ _____

Signature of patient / responsible party **Date**