# FINANCIAL POLICY
## **PLEASE REVIEW, SIGNATURE IS REQUIRED**

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. The following is our financial policy, if you have any questions; please feel free to discuss them with our staff.

All patients are ultimately responsible for their own bill. Patients who have health care coverage are responsible for providing the office with complete and accurate information regarding their insurance. You are responsible for obtaining necessary referrals for your initial office visit – the office will request referrals for additional visits and surgeries.

Patients without health coverage are expected to pay in full at the time of service. If full payment is not possible, a payment plan can be arranged with the office manager. All payment plans require 50% of the bill to be paid at the time of service.

For your convenience we accept VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

**MINOR PATIENTS:**
These policies apply to minor patients also. We strongly recommend the minor's responsible party accompany them to the office. If this is not possible the adult accompanying the minor is responsible for seeing that our policies are met. (Minors and adults other than the responsible party cannot sign office paperwork).

**INSURANCE:**
We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any *required copayment at the time of service.* Because billing and mailing statements is an expensive process, we ask that your portion of our fees, including deductibles and copays, is paid at the time of your appointment. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of our statement.

If your insurance plan is one with which we do <u>not</u> have a prior agreement, we will prepare and send the claim for you on an unassigned basis. In this case, your insurer will send the payment directly to you; therefore charges for your care and treatment are due at the time of the service.

*I have read and understand the financial policy of the practice and I agree to be found by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.*

_____ _____
Signature of Patient or Responsible Party Date

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Please Print the Name of the Patient