Financial Agreement

We are participating providers for Medicare, as well as many HMO & PPO plans. We will file claims on your behalf. You will be responsible for all balances, copays & deductibles, per your insurance explanation of benefits. You are responsible, as the insured & the patient, for providing our office with a copy of your current medical insurance. If you do not inform us of any changes, or provide us with correct information, you will be responsible for charges incurred.
Payments (copay & deductibles) are due at the time of service. We accept cash, checks, Master Card, Visa & American Express. For any checks returned for non-sufficient funds, will result in a $25 fee.

Referrals & Authorization

This office requires a minimum 5-7 business days to process routine authorization requests. If applicable, you are responsible to ensure that any insurance referrals and/or authorizations are obtained prior to your visit, or procedure by a specialist. Short (less than 5-7 business days), or no notice from you, may result in canceling or rescheduling your appointment with the specialists.

Notice of "Non-Covered" Services

I am aware that some services performed by the practice may be considered "non-covered "by my insurance carrier, or Medicare, therefore, I will become financially responsible for payment of these services.

Notice of Missed Appointment Fee

Our office requires 24 business hours to cancel or reschedule. Failure to provide the required 24-Business hours notice, will result in a **$35 fee. Any missed appointment fees must be paid prior to being seen.**

This office provides sign language interpreters for those in need. However, please be aware, if you do not show up or cancel within 24 business hours of your scheduled appointment, you will be responsible to pay for the minimum fee assed by the interpreter. **(The fee may vary by interpreter, typically (a 2-hour min) which is currently $140- If you incur this fee, it must be paid to our office, prior to rescheduling the missed or short notice of cancelation, appointment.**

Collections Policy

Should your account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection & attorney fees for collection expenses in addition to any outstanding bills.

Patient's name (PRINT) ____ Date______________

Signature of Patient (or legal guardian-if legal guardian, relationship to the patient__________)

X ____