# Financial Policy

Thank you for choosing me as your health care provider. I am committed to your treatment. The following is a statement of my Financial Policy, which I require you to read and sign prior to any treatment:

1. All patients must complete the patient information and insurance form before seeing the doctor.

2. I accept cash and check and credit cards. Co-Payments must be paid when you arrive at the office for your appointment.

I have contracts with most commonly used insurance companies. Please check to see if I accept your insurance. If I do not accept your insurance policy, as a courtesy, I will bill your company. Your insurance policy is a contract between you and your insurance company. I am not a party of that contract. If I bill your insurance company and they have not paid your account in full within 45 days, the balance may be automatically transferred to your credit card or billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

**Regarding insurance plans where I am a participating provider:** All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional Co-Payment, Deductible or Co-Insurance. Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where I am not a participating provider, refer to the above paragraph.

**Usual and customary rates:** My practice is committed to providing the best treatment for my patients and I charge what is usual and customary for my area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

**Minor patients:** The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or payment by cash or check at the time of service has been verified.

**Missed appointment:** Unless canceled at least 24 hours in advance, you may be subject to $25.00 no-show fee at the physician's discretion. Please help us serve you by keeping scheduled appointments.

**Co-pays and Balances:** Co-pays are due at the time of service. If I need to bill you for the co-pay, there will be an additional $5.00 processing fee. You will also be asked to pay any outstanding patient balance.

**FMLA Documentation:** There will be a $25.00 fee for completion of FMLA/Return to Work documentation.

**Insufficient Fund Fee:** Checks that are returned will be charged a $45.00 insufficient funds fee.

**Collection Fee:** Unpaid balances may be turned over to an outside collection agency. In the event your account is turned over for collections, you as the patient will be responsible for all fees and costs associated with collecting the balance.

I have read the Financial Policy and I understand and agree to its provisions.

_____ Date_____

Signature of patient or responsible party