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# Financial Policy

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment for services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the physician and you (the patient) and our contract is with you. We will not compromise your medical care to satisfy **ANY** insurance company. Bear in mind, insurance is meant to help defray the cost of medical care and is **NOT** intended to dictate your treatment.

Payment is due and expected in full at the time services are rendered unless other arrangements are made PRIOR to your appointment. This includes deductibles, co-payments, co-insurances, and non-covered services.

As a courtesy we are happy to assist you in the filing of most insurance claims, completing insurance forms, and insurance pre-certification. You will be responsible for all balances not covered by your insurance. If your insurance has not paid their portion within 60 days of being properly billed, the entire balance will be your responsibility. The **ULTIMATE RESPONSIBILITY** for the filing and processing of claims to satisfy your insurance carrier **REMAINS WITH YOU**. If you are unsure of any specific requirements of your insurance, **PLEASE ASK THEM.** We are unable to be completely familiar with every type of insurance and plan. As the insured client, you are in the best position to follow up and exert pressure on your insurance carrier to ensure payment is being processed.

You will receive a monthly statement requesting payment of any unpaid balance. If your account becomes past due, please contact our office to discuss payment arrangements and avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but we are unable to assist if you do no contact us to discuss your account.

There is a fee (currently $35) for any checks returned by the bank. Patient balances that go unpaid for 90 days or more will incur additional interest charges of 1% per month of 12% APR. Appointments not cancelled with 24 hour notice may result in charges for time reserved.

We are here to serve your health needs and will work hard on your behalf, to contain fees and other charges while providing you with quality health care.

**I have read and understand the above policies. I understand that I may receive a copy of this form upon request.**

_____ X_____

Print Patient Name/ Date of birth | Signature of Patient or Responsible Party

_____ _____

Witness | Date