

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. We may bill your insurance as a courtesy. We are not participating providers with every plan so it is your responsibility to note any coverage differences if we are in or out of network.
2. Although we may verify your insurance to estimate any coverage you may have, you are ultimately the responsible party and when you start care, you agree to accept responsibility to pay for all services rendered and any balances on your account.
3. Any patient with a high deductible plan (\$500 or greater) will be required to pay up to \$100 at each visit if billing insurance and your deductible has not been met.
4. We submit to secondary insurance plans only if we are required as contracted providers.
5. MEDICARE: We are non-participating, and do not accept assignment. We are required to collect fees up front from the patient for all services on the day of service. We will provide you with that information before services are rendered.
6. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. As such, we are obligated to collect those amounts at time of service.
7. PERSONAL INJURY/WORK COMP: Please see LIEN form. We may collect from the patient at any time for all services rendered, whether or not there has been any payment, judgement or settlement.
8. If you have no insurance, or choose not to have insurance billed, payment is to be made in full at the time of the visit.
9. We do not have special fees for patients with or without insurance, but have the same fee schedule for all of our patients.
10. We do offer a "time of service" or "bookkeeping" discount for patients who pay in full at the time services are rendered. To be eligible to receive this discount, there must be:
 - a. no outstanding balances on your account and
 - b. you must pay the entire bill in full on the date that services are rendered. (This means that we do not balance bill you, send you a statement or accept installment payments.) and
 - c. we will not complete any additional paperwork that may be required to process a claim or obtain reimbursement from your health insurance, PI, flex plan or HSA.
11. If you have insurance and choose to utilize the time of service discount, you must pay the entire balance in full. This includes both your portion (co-pay, co-insurance, and/or deductible) as well as any anticipated insurance portion, if we are contracted providers with that plan.
12. We reserve the right to be paid IN FULL for NO SHOWS, late cancellations, and repeat cancellations.
13. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. We will send you a statement reminding you of this balance and your remittance is due *within* 10 business days of your receipt of your bill.
14. We do not let patients carry a balance higher than \$100.
15. We reserve the right to turn over any unpaid balances to a collection agency, and will so after failed attempts of payment. You are responsible for interests and any additional fees related to collections.
16. A **\$25** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
17. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
18. We require a credit card number on file.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name _____ Date _____