OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, AND CREDIT CARDS
WE OFFER AN EXTENDED PAYMENT PLAN

Regarding Insurance – We may accept insurance benefits on your first visit after verification of benefits. However, we require 20% of the bill paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you bring all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, we require that you be pre-approved on our extended payment plan. If your insurance company has not paid your account in full within 45 days, the balance will automatically transferred to your extended payment plan. Please be aware some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Adult and Minor Patients – Adult patients are responsible for full payment at time of service. The parents or guardians are responsible for full payment of a minor. For unaccompanied minors, non-emergency treatment will be declined unless charges have been pre-authorized to an approved credit plan, credit card, payment by cash or check at time of service.

Missed Appointments – Please cancel at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Signature of Co-Responsible Party Date