FINANCIAL POLICY

Thank you for choosing us as your health care providers. We are committed to your receiving the best quality medical care possible. The following is a statement of our Financial Policy. We ask that you read and sign it prior to any treatment.

FULL PAYMENT OF HMO/PPO COPAYS IS DUE AT TIME OF SERVICE.

FULL PAYMENT IS DUE AT TIME OF VISIT FOR SERVICES NOT COVERED BY INSURANCE.

WE ACCEPT CASH, CHECKS, VISA/MASTERCARD AND DISCOVER.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. Please be aware that some and perhaps all of the services provided may be non-covered services, or not considered "medically necessary" under the Medicare Program, and are therefore your responsibility. If your insurance company has not paid your claim within 45 days, the balance will automatically be billed to you.

FULL PAYMENT IS YOUR RESPONSIBILITY IF YOUR INSURANCE COMPANY DOES NOT PAY OUR BILL FOR ANY REASON. IF YOU BELONG TO AN HMO/IPA NETWORK, FULL PAYMENT IS YOUR RESPONSIBILITY IF YOUR INSURANCE COMPANY DOES NOT PAY OUR BILL BECAUSE WE ARE NOT PART OF THEIR NETWORK. IT'S IMPORTANT THAT YOU CALL YOUR INSURANCE COMPANY TO VERIFY YOUR DOCTOR IS IN NETWORK PRIOR TO YOUR APPOINTMENT AND OBTAIN ANY NECESSARY REFERRALS AND AUTHORIZATIONS NEEDED.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

We reserve the right to charge for appointments not cancelled at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

PAST DUE ACCOUNTS

Accounts are considered past due after 30 days. After 180 days, past due accounts will be turned over for collections. If an account is in collections and no attempt has been made to clear the account or reasonable payment arrangements made, routine care will be discontinued until the account is paid in full. **I UNDERSTAND I AM RESPONSIBLE TO PAY FOR SERVICES RENDERED, INCLUDING REASONABLE ATTORNEY'S FEES AND COSTS OF COLLECTION IN THE EVENT OF DEFAULT.**

OVERPAYMENTS

All overpayments are credited to your account. Overpayments will remain credited to your account for future use unless you request reimbursement.

I HAVE READ AND UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X____

PATIENT **DATE**

X____

PARENT FOR GUARDIAN IF PATIENT IS A MINOR **DATE**