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Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial polices as an essential element of your care and treatment.

- If you are not working with insurance, full payment is expected at the time of service unless other arrangements have been made. For your convenience, we accept Visa, MasterCard, bank debit cards, personal check, and cash. Payment is for services rendered and there is a policy of NO refunds.
- Your insurance policy is a contract between you and your insurance company. As a courtesy we will file your insurance claim for you if you assign the benefits to the doctor; therefore you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, you will be responsible for payment. If we later receive a payment from your insurer we will refund any overpayment to you.
- We have made prior arrangements with many insurance plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will only require a co-payment at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health insurance determines a service to be "not covered" or that a service will be applied to a high deductible health plan you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services provided in the hospital, we will bill your insurance. Any balance due is your responsibility and we will bill you for these balances.
- For all services rendered to minor patients, the accompanying adult or the parent /guardian with physical custody will be responsible for payment.
- I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand that I will be responsible for any legal cost if my account goes to collections.

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Signature of Patient or Responsible Party if Minor Date