FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
    - Bring your insurance card to every visit. We cannot file an insurance claim without a current card on file.
    - Be prepared to pay your copayment at each visit. Payment can be made by cash, check or credit card. If you do not bring payment to your visit and we have to bill you, you will be assessed a $5 administrative fee.
    - For medical care <u>not covered</u> under your insurance, payment in full is due at the time of the visit.

2. If you are unable to pay for necessary medical care, it is your responsibility to inform us prior to the visit so that we can arrange a payment plan.

3. We do not participate with commercial insurance but as a courtesy we will file claims for a number of companies. Please check with our receptionist. This may mean that your copay will be determined by your out of plan benefits.

4. You are responsible to make payment in full for any services not paid by your insurance company. Failure to do so will result in the account going to a collections agency.

5. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (number is on your insurance card).

6. If you are unable to keep an appointment, please give 24 hours notice or you may be charged a $50 no show fee.

Our practice believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the Office Manager. Please sign that you have read and agree to this Financial Policy.

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Signature of Responsible Party Date

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____