Patient Name: _____

Payment Policy

Thank you for choosing us as your health care provider. We are committed to providing you with excellent, affordable. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy to answer frequently asked questions. Please read it, ask us any questions you may have, and sign in the space provided.

□ Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and select insurances.

□ If you do not have insurance, payment is due in full the day of your visit.

□ If you have insurance all co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

□ ALL payment arrangements need to be made BEFORE the day of your appointment.

□ It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of a claim.

□ We will submit your claims and assist you in any way we reasonably can to help get your claims paid. We file your insurance as a courtesy. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or nor your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Our practice is committed to providing the best care to our patients. Our fees are representative of the usual and customary charges for our area. Thank you for understanding our policy. Please let us know if you have any questions or concerns.

I have read and understand this policy and agree to abide by its guidelines:

_____ _____

Signature Of Patient or Responsible Party Date