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Financial Policy

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, unless other arrangements have been made in advance by either yourself or your health coverage carrier (medical insurance). For your convenience, we will accept VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER.

YOUR MEDICAL INSURANCE

If you do not bring us sufficient information to bill your insurance (including name, address and phone numbers of the insurance company, medical group name if relevant, ID and group numbers, as well as date of birth and name of the subscriber), then full payment is due at the time of service.

IT IS THE POLICY OF OUR OFFICE TO COLLECT ANY COPAYMENT WHEN YOU ARRIVE FOR YOUR APPOINTMENT. We hold contracts with many insurers and health plans. We will bill those plans with which we have a contract, and will only require you to pay the authorized co-payment at the time of service. You are also responsible for your deductible, share of cost, coinsurance, and any costs not a benefit of your plan.

If you have insurance coverage with a plan with which we do NOT have a contract, we will be happy to prepare and send a claim for you on an unassigned basis. This means that your insurance will most likely send payment directly to you. Due to this, payment is due upon receipt of a statement from our office.

MINOR PATIENTS:

For all services rendered to minor patients, the parent or guardian is responsible for payment.

I have read and I understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I authorize payment of medical benefits to be made directly to the physician provider for services rendered. I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies.

PLEASE PRINT NAME OF PATIENT ________________________________

Signature of Patient ____ Date: __________

Signature of Responsible Party if Patient is a Minor: _______________________Date:__________