FINANCIAL POLICY

We are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities as our patient. It is your responsibility to contact our office to notify us of any changes to your information, such as a change in address, telephone number, or insurance information.

You must complete and sign our Financial Policy before care is rendered.

- Payment is due at the time of services, including copayments, deductibles, and coinsurance as applicable. If you are uninsured or if you are not insured by a plan we do business with, payment in full is expected at time of services.
- If you are insured, You must bring your insurance information and a photo ID to every appointment to ensure correct processing of all insurance claims. If you are insured by a plan we work with but do not have your up-to-date insurance card, payment in full is required at time of services if we cannot verify your coverage.
- It is your responsibility to understand your insurance policy and benefits.
- We file insurance claims as a courtesy to our patients. Your insurance company may need you to provide certain information directly to the insurance company. You are responsible for complying with their request.
- If your insurance company denies payment because of benefit limitations or noncovered services, you will be responsible for the charges.
- If your insurance company needs any additional information, you are responsible for providing it to the insurance company.
- There is a **$50** fee for all returned checks.
- We reserve the right to bill you for a missed or "no-show" appointment without appropriate notice of cancellation. If you do not show up for an appointment or cancel with less than 24 hours' notice, you will be charged **$50**. Patients with three missed appointments may be terminated from the practice.
- There is a **$10** fee for copies of medical records and a **$30** fee for completing Disability and FMLA forms.

I have read, understand, and been allowed to ask questions about this policy. I agree to comply with the policy as described.

________________________________ __________________

Patient Signature Date

________________________________ __________________

Responsible Party Signature/Relationship Date

________________________________ __________________

Printed Name Date