FINANCIAL POLICY/AGREEMENT FORM

Patient Name: _____

Date: _____

This financial policy/agreement form helps to clarify the payment policy of our practice, and to make sure you understand our expectations regarding payment. Please read the following information carefully. Thank you for understanding and please let us know if you have any questions or concerns.

INSURANCE

We participate in some insurance plans. If you are not insured by a plan we participate with, payment in full is expected at the time of service. If you are insured by a plan we participate with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. 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 and is part of the compensation plan. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

NON-COVERED SERVICES

Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full if denied by your insurance company.

CLAIMS SUBMISSION

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

NONPAYMENT

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full or make payment arrangements. Please be aware, while we will strive to work with you, if a balance remains unpaid, we may refer your account to collections.

MISSED APPOINTMENTS

Our practice charges $50 for missed appointments. These charges will be your responsibility and billed directly to you.

By signing this form, you are agreeing to comply with and accept the above financial policy.

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if applicable): _____
Date: _____