FINANCIAL RESPONSIBILITY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of our treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will be happy to file your insurance claims for you. However, we do require co-pays and deductibles to be paid at the time of service. We cannot bill your insurance company unless you provide us with correct insurance information, both primary and secondary and requested forms of other identification such as driver's license. Your insurance policy is a contract between you and your insurance company. We will accept the contracted allowable fees if we participate with your specific insurance plan.

MEDICARE PATIENTS

We are participating providers and accept assignments for Medicare benefits. We are also a provider for many of the Medicare replacement plans. However, you are ultimately responsible for any deductibles and the difference between the amount approved and the amount paid by Medicare and your secondary insurance when applicable. Please be aware that certain services provided may be non- covered services and/or considered reasonable and necessary under the Medicare program. Under these conditions you will be required to sign an Advanced Beneficiary Notice (ABN) for these specific services.

USUAL AND CUSTOMARY

We are committed to providing the best treatment for our patients and our services reflect usual and customary fees for our area. You will be notified prior to any procedure or service which may not be covered by your insurance so payment can be made.

RETURNED CHECKS

We charge a $35.00 fee on all returned checks.

Please note if your account is sent to an outside agency/attorney for collection of an unpaid balance a fee of 35% will be assessed on top of your outstanding balance.

I have read and understand the above and agree to comply with this Financial Policy.

Signature of patient or responsible party _______________________________Date_____________