



Clinic Financial Policy

*Fees are important issues to anyone receiving professional services.
Please ask the office staff if you have any questions regarding this information.*

Payment Methods: Payment is required at time of service. We do not accept cash payments. Checks, debit or credit cards are accepted. You may authorize a card payment with our front desk staff, in person or over the phone. You may pay online at olivebranchok.com via the clinic's square account found under the "Payments" tab. If a check bounces, you will be charged an additional \$35.00 for each presentation to the bank. If you receive services on an ongoing basis, you may request a monthly statement.

Insurance: By signing this document you agree to authorize the release of any and/or all of your information necessary for checking benefits, filing claims, pre-certification, concurrent review, and/or retroactive chart reviews. If you are utilizing your private insurance you are obligated to pay your copay(s) and deductible(s) at the time of service.

Past Due Accounts: Past due balances can get expensive, therefore if your balance reaches \$200 or over, we will be inclined to cancel any future appointments until any payments can be made or payment arrangements are set up. Payment plans can be set up at the office or by phone.

Missed Appointments: If an appointment is canceled or missed without sufficient notice (by noon, one business day before appointment), you will be billed a \$50.00 No-Show fee which must be paid prior to having another appointment.

Responsible Party: If you are over 18 years old you are responsible for making payments for services. If the patient is a minor, the parent/guardian will be responsible for payment. We will attempt to collect payment from 3rd party payer(s), but if this fails, payment will be expected from the patient or parent/guardian of the minor.

Collections: All accounts 60 days overdue are subject to be turned over to a collection agency or legal action; unless a payment agreement can be reached. Personal information will be disclosed for necessary collections and/or legal action.

I hereby consent that I have read and agreed to Olive Branch Clinic's Financial Policy.

Date: _____

Signature of: Parent Guardian Client 18 years or older Other (specify) _____

Witness Signature