Financial Policy/Assignment of Benefits/Consent to Treatment

This policy has been established to help us serve you better.
It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late- cancellations delay the delivery of health care to other patients, some who are quite ill.

A "No Show" is missing a scheduled appointment. A "Late Cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office visit. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

Payment for services is due at the time services are rendered. Methods of payment: Cash, American Express, MasterCard, Visa and Discover. (Returned check fee is $25.00).

We are happy to assist you in processing your insurance claim, however insurance coverage is a contract between you and your insurance company and you are ultimately responsible for payment of your bill.

I understand that I may be billed for any out of pocket or reasonable collection fees if my account is not paid in a timely fashion. If it becomes necessary to pursue legal action to attempt to collect any outstanding balances, I agree that I am responsible for any and all attorney fees, court costs and any and all other costs deemed reasonable and customary and/or that may be allowed by the Court.

I hereby authorize and direct my insurance company to make payment to my physicians, providers and/or associates for services rendered and acknowledge that I am financially responsible for all non-covered services. I also authorize my provider to release to my insurance company any information necessary to process my claims. A photocopy of this assignment shall be considered as effective as the original.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status. I hereby authorize the healthcare staff to perform the necessary services I may need.

I certify that I have read and understand the foregoing "Financial Policy/Assignment of Benefits/Consent to Treatment" and agree to all terms and conditions as stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, HMO or PPO, Medicare/Medicaid or other benefits programs and that I am ultimately responsible for payment in full of any outstanding balances.

A charge of $25.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

_____ _____

Signature of Patient/Policyholder Date

_____ _____

_____ _____

Signature of policyholder/responsible party (if other than patient) Date