

Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to treatment. All patients must complete our information and insurance forms before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA & MASTERCARD.

Insurance

In the event we are not participating with your insurance plan we require payment in full at the time service.

All copays and deductibles are due prior to treatment. In the event surgery is required we will bill your insurance on your behalf. Deductible and coinsurance is due prior to surgery being scheduled. Be aware that some services may not be covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance and therefore you will be responsible for these charges.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

If patient is under the age of 18 a parent or legal guardian must be present to sign prior to treatment.

Signature of parent/legal guardian _____

Relationship to Patient _____

Unless cancelled at least 24 hours in advance, our policy is to charge \$25.00 for established patient and \$35.00 for new patient missed appointments. Please help us to serve you better by keeping scheduled appointments.

Checks returned will be charged \$25.00 service fee and only cash will be accepted thereafter.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read, understand, and agree to the Financial Policy.

Signature of patient or responsible party

Date