Financial Policy
INSURANCE

Our practice is committed to providing the best treatment for our patients. We must emphasize that as Medical Care providers, our relationship is with you, our patient, not with your insurance company. We cannot accept the responsibility of negotiating the claims with insurance companies or any other persons. While the filing of insurance claims is a "courtesy" that we extend to our patients, all charges are your responsibility from the date of the services rendered.

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claims, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Some and perhaps all of the services may be considered "Non-Covered" services and not considered necessary under Medicare and other medical insurance programs. Please remember that professional services are rendered and charged to the patient, not the insurance company.

We charge what is usual and customary for our area. The patient is responsible for payment in full within a reasonable time regardless of the status of the claim or any insurance company's arbitrary determination of usual and customary rates. Our fees are considered to fall within the acceptable range of most companies and therefore are covered up to the maximum allowance determined by each carrier.

If you have a managed care medical insurance that we participate with, your payment of deductibles, non-covered services and co-payments are due when services are rendered. If we do not participate with your insurance company or if you do not have health insurance coverage, payment for service is due at the time services are rendered unless our office manager has approved special arrangements.

Although an insurance claim is filed, you will receive a monthly statement if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. The patient is responsible for payment of the account within limits of our credit policy. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, or in circumstance where a claim is pending or when treatment will be for an extended period of time, it is recommended that a payment plan be initiated. We encourage you to contact our office manager for assistance in the management of your account.

RETURNED CHECKS

Any returned checks are subject to a $25.00 service fee. Any returned check must be resolved before any further appointments can be arranged.

MINOR AGE PATIENTS

For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized prior to date of service. The adult accompanying a minor and the parents or guardians are responsible for the payment in full.

No Show and Cancelled Appointments

All scheduled appointments that are missed or cancelled without a 24 hr. notice may be charged a $25.00 fee.

Permission to Give Medical Information

This information is needed for ANYONE calling our office for information regarding the patient. Please list any and all persons (including yourself) that you wish to be authorized to have this information. If the patient is a minor, both parents (grandparents, stepparents, etc.- regardless of guardianship/custody) that you wish to be authorized persons should be listed or we will be unable to speak to them regarding the patient.

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

I understand I may revoke the consent at any time by giving written notice to the person or organization making the disclosure.

I have also read and understand the financial policy of the practice and I agree to be bound by its terms.

Signed:______________________________ **Date:**____________________

(Patient/Parent/Legal Guardian)