**FINANCIAL POLICY STATEMENT**

The policies listed herein have been approved by the management with the goal of providing the finest care and services to our patients at the least cost.

Care delivered by this office will be administered regardless of race, color, social status, national origin, handicap or gender.

We are committed to providing you with the best possible care. In order to accomplish this, we your assistance in reading and understanding financial responsibility and our payment policy.

RESPONSIBILITY FOR THE BILL

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. While the office will file, verified insurance claims for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the practice in effect at the present time

POINT OF SERVICE COLLECTIONS

Payment for service is due at the time of service is rendered and non-emergency services may be declined until the necessary payment arrangements have been accomplished.

Payment will be accepted in checks and all major credit/debit cards. We will be happy to file verified insurance on your behalf. For your convenience if your check is dishonored or returned for any reason, we will be electronically debit your account the amount of the check plus a processing fee of $50.00.

Patients paying out of pocket for the services rendered are considered self payments. Payment is due at the time service, a $120.00 for Initial Consult and $80.00 follow ups.

Patients unable to comply with the Point-of-Service payment policy will be referred to the administrative office for necessary arrangements

PAYMENT ARRANGEMENTS

The practice will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangement for payments will be made at the office’s discretion, based on the amount of the patient’s liability and the patient’s ability to pay based on completed credit application.

ACCEPTANCE OF INSURANCE

The practice will accept “Assignment of Benefits” on verified insurance policies and submit a bill to carrier on the patient’s behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Claims filed will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all the claims not paid within the allowed period of time.

VERIFICATION OF INSURANCE

Because of the wide range of insurance plans in effect, the clinic will verify insurance coverage, deductibles and other limits, prior to acceptance for payment of services

REJECTED CLAIMS

Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf.

RELEASE OF INFORMATION

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

PATIENT RESPONSIBILITY

Balances after insurance are due within 30 days of the insurance payments, unless other satisfactory arrangements have been made with the practice.

Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers the service or not.

The practice cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

OUTSTANDING BILLS

The clinic reserves the right to request deposits and payments for outstanding balances. Deposits will be based on the outstanding balance plus the patient’s share of the bill for the new services to be performed.

HEALTHCARE LIENS

The clinic reserves the right to file healthcare liens against the patient and other responsible parties as is deemed appropriate to protect the practice interest.

BAD DEBTS/LEGAL ACTIONS

If the account is not paid in full or satisfactory arrangements made within the allowable time frame, the practices reserves the right to refer the account to an attorney and/or a collection agency for collections of the balance.

I agree to assume responsibility for all charges incurred should collections of this balance become necessary including court costs and attorney’s fee.

The administrative and management welcomes the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality healthcare

I have read the *Financial Policy/Policy Statement* and understand regarding above.

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Patient/Guarantor Date

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Witness Date