Our Financial Policy

- **It is your responsibility to determine whether services to be provided are covered by your insurer.** You are responsible for and agree to pay at the time of service for: required co-payments, co-insurances, deductibles, the cost of supplies and/or services (not covered by insurance), outstanding balances, and delinquent accounts.
- We will need a copy of the front and back of your photo ID and insurance card at each visit. You are expected to inform us of any changes in coverage prior to the appointment.
- If you have two (2) insurance plans, it is your responsibility to inform us which plan is your **PRIMARY** (first) coverage and which plan is your **SECONDARY** (second) coverage. You must inform us if one or both insurance plans change or are no longer effective.
- If you have an insurance plan that we do not have a written agreement with then you are responsible for payment, in full, for that day's visit.
- Co-payments will vary depending on your insurance plan and are due upon sign-in, **prior** to seeing the doctor. ***Note: there may be an additional payment due at check-out for any supplies/devices dispensed during the visit.
- If a billing statement is generated for an uncollected copay, a $5.00 processing fee will be applied.
- There is a $25.00 fee for completion of forms, reports, and letters since this is a non-insurance covered service. All fees are due at the time the form is delivered.
- If your insurance plan requires a referral from your primary care physician, you are responsible for obtaining this referral prior to your visit or full payment will be expected for the services rendered. **All referrals must be presented to our office before seeing the doctor.**
- There is a $50.00 charge for all returned checks.
- If your account is forwarded to a collection service and/or an attorney because of non-payment, you will be responsible for all costs incurred.
- **We reserve the right to deny non-emergency services if your account is delinquent.**

By my signature I acknowledge reviewing the financial policies and hereby agree to their terms.

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PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

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PRINT PATIENT'S NAME