Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Policy: Please read, initial in front of each number and sign at the bottom**

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, **Initial each space and sign at the bottom**. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don’t have up-to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-Payments and deductibles.**  **All co-payments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. We may make exceptions on a case by case basis. Should we make an exception and you are billed for you co-pay or deductible there will be a $5.00 billing fee. In addition, any balance over 30 days will be assest a **$5.00 service charge, per month**.
3. **Non-covered services.**  Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Our office does our best to know what is and what is not covered but ultimately it is your responsibility to know what your insurance will cover.
4. **Insurance Denial.** Charges denied for any reason by the Explanation of Benefits of your insurance company are due upon receipt. If you are not in agreement with your insurance company, you must pay for the services rendered and wait for reimbursement from your insurance company. We will be glad to resubmit the claim for you or help you if we can.
5. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
6. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
7. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
8. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice In care of default payment, **I agree to pay any and all costs of collecting this account including but not limited to 1.5% per month and up to 35% collection fees, attorney fees and court costs.**
9. **No Shows.**  If you no show (do not call and cancel) or give 24 hours’ notice you will be charged a **$25.00 to $50.00 fee**. In addition, if you no show (do not call and cancel) two times you and your family may be released from our office.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usually and customary charges for out area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_