PATIENT FINANCIAL POLICY

Many insurance plans require deductibles and co-pays to be paid at the time of service. If you are unable to make your payment at the time of your visit, you will need to be rescheduled. Our policy will require all new and established patients and those that require any procedure to pay remaining balances in full or set up a payment plan with our billing team prior to any procedures being performed. The amount collected will be the financial responsibility that the insurance company requires you to pay for services being rendered.

When will I be expected to pay?

- Collecting co-pays, co-insurances, and deductibles
- Outstanding balances
- Prior to surgical procedures

Our billing company ensures all claims are submitted and properly adjudicated prior to requesting payment. Most members will receive their explanation of benefits prior to their physician's office. You should reach out to your insurance company immediately if you have any questions, concerns, or issues.

Know your health benefits! As a courtesy to our patients, our billing company will submit all medical claims on your behalf. We will do our best to verify your benefits prior to your appointment. However, it is the patient's responsibility to know the details of his/her specific plan. It is your responsibility to know if a referral or insurance authorization is necessary for your visit/procedure. We can never guarantee that your insurance will pay all portions of your bill. If your claim is denied, you are responsible for the amount due to your account.

Cancellation/No show Policy: OFFICE VISIT: 2 BUSINESS DAYS NOTICE IS REQUIRED. FAILURE TO PROVIDE ADVANCE NOTICE WILL RESULT IN A FEE OF $50. Insurance will not cover this fee.

PROCEDURE VISIT: 2 BUSINESS DAYS NOTICE IS REQUIRED. FAILURE TO PROVIDE ADVANCE NOTICE WILL RESULT IN A FEE OF $100. Insurance will not cover this fee.

I understand that my insurance policy may include a deductible and/or co-insurance that applies to my medical treatment today and for future services which I am responsible to pay, and I agree to the terms above.

Patient Signature: _____ Date: _____

Patient Printed Name: _____ Date of Birth: _____