PATRICK L ALLEN, M.D. FINANCIAL POLICY
All patients must read, initial, and sign this form prior to receiving services

_____**Missed/Late cancel:** If you cannot keep a scheduled appointment, you must call and cancel or reschedule at least 24 hours prior to appointment. Failure to do so will result in a $25.00 charge to your account. These fees are for each occurrence and is not covered by your insurance.
_____**Proof of insurance:** Please bring your current, valid insurance card and ID/DL with you to every visit and we will do periodic updates on patient forms. If you fail to provide accurate insurance information at the time of service, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for all charges.
____**Insurance:** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it.
_____**Co-payments & deductibles:** Payment is due in full at time of service, which includes deductible, coinsurance, co-pay, and any percentage that is your share and not covered by your insurance. This arrangement is part of your contract with your insurance company.
____**Claims submission:** Your insurance is a contract between you and your insurance company. It is your responsibility to know and understand what services are covered by your insurance. We bill your insurance as a courtesy to you. Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please be aware that some or perhaps all of the service provided may not be covered in full by your insurance. You are financially responsible for any services not covered by your insurance.
____**Payment options if you DO NOT have insurance:** We require payment for all office visits and procedures be paid at the time of service. You may choose to pay by cash, debit, check or credit. If extensive treatment is required, you may discuss the option of a payment schedule with our billing department.
____**Returned checks:** There is a fee of $35 for any checks returned by the bank.
____**Monthly statement:** We will send a statement to the billing address you provide notifying you of any balances you may owe. Payment is due in full upon receipt. If you have any questions about the validity of your balance it is your responsibility to contact our office within 15 days.
____**Past due accounts:** If you fail to make payments as agreed or past due 90 days, your account will be referred to a professional collection agency. You will be responsible for all collection cost incurred, including collection agency fees. If you're your account is assigned to a collection agency, you will be notified by certified mail that you will no longer be able to receive services. Failure to accept this certified letter, serves as notice of termination until your account has been reinstated to a satisfactory status.
____**FMLA or other insurance forms:** There will be a charge for the completion of medical forms. Pre-payment of $25 required for the completion of the forms. Please allow five to seven days for completion of the forms.
____**Effective date:** Once you have initialed each line and signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: ____ Date of birth:________________

Responsible party (if not patient)____

Signature: ____Date:_____________