Office Financial Policy

_____ **It is the policy of this office to receive payment at the time that services are rendered.**

_____ We strive to provide the ultimate in care and reduce any difficulties in the medical billing process. We participate in most insurance plans.

_____ If we are a participating provider with your insurance company, your co-pay or deductible is due at the time of the office visit.

_____ If you do not have a current insurance card, payment is due in full for each visit until we have a copy of your card AND coverage can be verified.

_____ Understanding your insurance benefits is your responsibility. We will do our best to provide accurate information regarding your benefits and estimate of costs prior to your appointment. To do this, we must be given accurate information before your visit. Please be aware that these are estimates and may not reflect actual costs. Please contact your insurance company with any questions you may have regarding your coverage.

_____ If you are not insured by a plan we are contracted with, payment in full is expected at each visit.

_____ Referrals are the patient's responsibility. In the event that an insurance claim is denied because of failure to obtain a referral, the fees for services will be the patient's responsibility.

_____ The parent or legal guardian assumes financial responsibility for the minor in the event that there is a balance owed after the claim has processed. In the case of divorced parents, the parent who carries the minor's insurance policy will be responsible for any balance due.

_____ We will pre-certify all elective surgeries for you. Any fee that is estimated to be your responsibility, will be collected before the surgery date at your preop appointment. Your surgery may be rescheduled if this portion is not collected. We will file with your insurance company.

_____ If you are hospitalized and seen by one of our doctors at an outside facility, these fees will be billed to your insurance company. You will be responsible for your portion of the fees.

_____ We expect complete resolution of any unpaid balance on your account within 90 days after your insurance company has made final payment. If the outstanding balance is not paid at this time, we will report you to the national credit bureaus. For all unpaid balances after 30 days, a $25.00/month handling fee will be added to your balance.

_____ Some treatments may not be covered under your insurance policy and payment of these treatments are expected at the time of service.

_____Some items offered in our office are not covered under your insurance policy and payment of these items is expected at the time of service.

_____ As a courtesy, we will file claims to your primary and secondary insurance. You are responsible for claims with any additional providers.

_____ We do not file with auto insurers. If you are injured in a car accident, you are responsible for recovering medical costs from your auto insurer. You will be expected to pay for services in full at each visit and we will be happy to provide a receipt.

_____ We do not file with schools. If you or your child are injured on school property, you are responsible for recovering medical costs from these facilities. You will be expected to pay for services in full at each visit and we will be happy to provide a receipt.

_____ If you are filing a workers compensation claim, we must have the claim number and your adjustors information prior to seeing you. Otherwise, you will be expected to pay for your visit in full at the time of service. If you file this claim after you have been seen in our office, please note we do not provide a refund for these services if your claim is approved.

_____ If you require a form to be filled out, we do charge a fee of $20.00 which is collected prior to completed the forms for you.

_____ If you request a copy of your medical records, there is a handling fee which is collected prior to completed this for you. Please allow 7-10 days from the date of request for us to copy these records for you.

I have read and understand the Financial Policy above. I have had the opportunity to ask questions regarding this policy.

_____
Patient or Guardian Printed Name

_____ _____
Patient or Guardian Legal Signature Date