Patient Name: _____ Patient #: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the Doctor.

Full Payment is due at the time of service unless other arrangements have been made. We accept cash, checks, Visa or MasterCard.

A $25.00 (twenty-five) service charge will be assessed to any returned checks.

In special situations we offer an extended payment plan.

REGARDING INSURANCE/ USUAL AND CUSTOMARY RATES:
We may accept assignment of insurance benefits; however, you are ultimately responsible for unmet deductible, co-payments, or any remaining balance on your account. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

MINORS:
The adult accompanying a minor and the parents (or legal guardians) are responsible for full payment.

PERSONAL INJURY CASES:
In special situations our office will extend credit to our patients so they can receive treatment. Our office will extend this credit for a period of sixty days following your release from active treatment. If the case has not settled within this period of time payment will be due in full. A payment plan may be arranged on a case by case basis. If at any time the case settles, payment in full will be expected immediately.

MISSED APPOINTMENTS
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

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

I have read the Financial Policy and understand and agree to these terms.

X_____ Date: ____/____/____

Signature of Patient or Responsible Party

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