

FINANCIAL POLICY

We are committed to providing you with best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

By signing below you agree to be financially responsible for medical services provided.

If you have Health Insurance, provide us with a current insurance card. You are responsible for payment of any co-pay, deductible, co-insurance amount or non-covered services.

Payment is expected at the time of the visit/service. We accept cash, credit card and checks.

Initial _____

We also require credit card information and authorization. Charges or refunds to your credit card will ONLY be made once your insurer has provided us with your EOB (explanation of benefits).

Failure to provide current insurance or credit card information will result in service charges to your account.

Patient Name: _____

Name on Credit Card: _____

Credit Card: DISCOVER____, AMEX____, MC____, VISA____

Credit Card Number: _____

Expiration Date: _____

I authorize payment of any amount due after insurance adjudication. (i.e.: co-payment changes, co-insurance amount, deductible).

Patient/Cardholder Signature: _____

Date: _____

E-mail address: _____

Service Charges/Fees:

First Bill for balance due: \$5.00

Each subsequent statement: \$10.00

Fee for Returned check: \$30.00

Interest on Balances > 45 days: 2% per month.

Accounts referred to collection will be charged \$50.00 or 25% of the balance, whichever is greater.

Patient Signature: _____ **Date:** _____