



## **Financial Policy**

Thank you for your expression of confidence by choosing our office for your medical care. We promise to work hard at making your experience here as satisfying as possible. Part of our relationship will involve the fees for the care we provide. We have developed the following Financial Policy to detail our expectations and reduce any confusion between us. Please read this Financial Policy carefully and sign in the space below to indicate your understanding of the terms.

### **Regarding Self Pay Patients**

We require **FULL** payment at the time of the appointment. We accept cash, personal checks, and major credit cards to assist you. Special payment arrangements are possible for patients with special financial needs. For further information, please ask to speak with a Patient Account Representative.

### **Regarding Patients with Insurance Coverage**

Insurance is a financial agreement between the insured and the insurance company. As a courtesy, our staff will file your claim with your primary insurance carrier without charge. We expect that you will pay your portion of the bill (co-payments and deductibles) at the time of each service. Please remember that should your insurance company fail to pay your bill for service within 60 days, the entire balance will become your responsibility. Should any payment by your insurance company result in an overpayment, we will make a refund as appropriate.

### **Regarding Non-Medical Fees**

We also require **FULL** payment for items such as medical record copies, completion of special forms and letters, and the processing of disability statements. These items are not covered by insurance.

Please feel free to ask any questions that you may have regarding this policy or how it may relate to your individual situation or insurance company.

My signature represents that I have read, understand, and agree to the policy described above.

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Date

