

**PATIENT FINANCIAL POLICY**

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Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for choosing us as your health care provider. We are committed to providing you with quality medical care. Please understand that payment for your bill is considered part of your care plan. We ask that you read and sign this Patient Financial Policy at your visit today.

1. Insurance is billed as a courtesy when you provide us with current insurance information and sign our Acknowledgment and Consent form. If you do not present a current insurance card at the time of visit, or do not sign our Acknowledgment and Consent form, you will be billed directly for the provided services. Please be advised that insurance is a contract between you and your insurance carrier. You are responsible for payment of your account.
2. Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered by your plan, or how it will be covered by your plan. We recommend that you contact your insurance carrier with any questions that you may have regarding your coverage for these services. You are responsible for knowing the details / rules of your health plan.
3. In the absence of insurance coverage, a $100 deposit is required at time of service. If you are unable to pay this deposit, upon request, a Financial Assistance Application will be given / mailed to you. Completed applications will be reviewed and you will be notified in writing of any amount the physician will write off. Reduction in your financial responsibility will be based on your ability to pay and not your willingness to pay.
4. If you have a balance due on your account, we will send you a bi-weekly statement. The balance on your statement is due and payable when the statement is issued and is past due if not paid within 30 days. If you are unable to pay in full you should contact our office to set up a payment plan. Dishonored checks will be charged $35.00.

1. If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection costs which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney fees including court costs.
2. You understand if this account is submitted to a collection agency or attorney, is litigated in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND THAT REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. I UNDERSTAND THAT DELINQUENT ACCOUNTS WILL BE ASSIGNED TO A CREDIT REPORTING COLLECTION AGENCY. IF IT BECOMES NECESSARY TO PROCEED WITH COLLECTIONS, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES.

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Patient / Guarantor Signature Date

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Print Patient / Guarantor Name Relationship to patient if not the patient