OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time or service or by an authorized payment plan. Your personal balance may not exceed $300 at any time or care may be terminated.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service. Your co-insurance balance may not exceed $300 or care may be terminated.

Health Insurance Members: You are considered a cash patient until you bring in your insurance card, and we accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Personal Injury Patients: You are considered a cash patient until you bring in your DECLARATIONS PAGE and the other persons' insurance information. We do accept assignment for third party insurance carriers. If you have an attorney, please provide the accounts manager your attorneys' name and phone number.

RELEASE: Please read HIPAA Notice of Privacy Practices. Sign here if you agree ______________________

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for recovery of the claim of $62.00 per date of service. Payment in full of any outstanding balance will be due, immediately.

I have been informed that in the event my insurance benefits are terminated or exhausted, I agree to pay all charges in full at the time services are rendered. In the event my account is turned over for collection, I agree to pay all costs of collections, including attorney's fees. A 2% interest rate per month will be charged to any outstanding balances for more than thirty (30) days, and I agree to these charges.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

CANCELLATION POLICY: Cancellations require a 24 hour notice. Missed appointments will be charged in full. Appointments changed with less than 24 hours noticed will be billed $50, unless scheduled for the same day.

NON-SUFFICIENT FUNDS: When paying with a check and it is returned unpaid by the bank, you will be charged a $26.00 NSF check fee.

I agree to all said policies above:

Patient Name (please print) ____________________________ Signature____________________________