

FINANCIAL POLICY

- ❖ Patients are responsible for providing all demographic and insurance information at the time of service. Billing your insurance company is a courtesy and all balances not covered by insurance are your responsibility.
- ❖ All office visit co-payments and co-insurance are due on the day of visit by cash, check or VISA/MasterCard. Until your insurance and deductible/co-pay amount can be verified you are responsible for the total payment of each office visit.
- ❖ You should check with your insurance company to verify coverage and verify provider participation.
- ❖ There is a \$25 fee for completing disability forms, leave of absence forms, etc. Fees are payable prior to the forms being completed. Please allow 5 -10 working days for completion of forms.
- ❖ There is a \$20 fee for checks returned for insufficient funds.
- ❖ If an appointment is made and is not cancelled 24 hours prior to the appointment time, a \$50 No Show charge will be applied to your account.
- ❖ In the event your account is past due with no payment, there will be a \$5.00 late payment fee assessed. If your account has a balance of 60 days or more you will be charged 18% interest on the outstanding balance.
- ❖ If your account is past due with no payment, it may be turned over to a collection agency. If your account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to collection agency fees of 50% of the balance due and costs and reasonable attorney's fee of 33% of the balance.

Please sign below if you have read and agree to the above policy.

Name (please print) _____

Signature _____

Date _____