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Financial Responsibility Policy Agreement

The purpose of this form is to outline our financial policies and your responsibility regarding charges incurred at our practice. We realize how confusing insurance reimbursement can be and hope this will answer any questions you have regarding your financial responsibility.

Patients without proof of insurance, which is required at time of service, are required to pay in full before service. Any patient with a prior balance on their account must pay the amount due before their appointment. We have the right to deny any patient that has an existing, outstanding, unpaid balance. Cash, Check, Visa, Discover, Mastercard, and Care Credit are all acceptable forms of payment. Sometimes the charge for a service cannot be determined until after the appointment, in which case, arrangements will be made to pay for the service after it is performed. You will be responsible for any non-covered services at the time of your visit. If you are covered through an insurance company with whom we do not participate with or if you do not have insurance coverage, you will be responsible for payment in full at the time of service.

Patients with Insurance coverage: We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. However, you are responsible for the payment of your account and responsible to resolve any problems with your insurer. It is also your responsibility to notify us of any changes to your insurance policy. We will bill you for any balance remaining after your insurance company pays and all applicable discounts have been applied. You are responsible for deductibles, co-insurance, co-pays and non-covered services. Please note, that although we may be participating with a certain carrier, your plan may specifically require a certain specific network of doctors/facilities within THEIR healthcare network to be used. This can occur sometimes for special contracted companies or certain discounted plans. It is the responsibility of the patient/and or parents/guardians/subscriber to know the rules of your insurance plan. We can help you understand the rules, but the insurance company will be the main source of information for your plan.

Outstanding balances: Patient bills are generated upon receipt from your insurance carrier. If there is a credit on your account, it will be applied to your balance. Any account balance outstanding more than 30 days will be charged additional finance charges and after 90 of no payment, it will be subsequently forwarded to our collection agency. Once a client is sent to collections, the parents/guardians, or the patient will be unable to receive medical care from this office until the account is balanced. This would include prescription refills, order fulfillment and/or after hour calls. Any accounts sent to collection agency will be responsible for the amounts owed to our practice as well as any assessed fees by the collection agency and or attorney costs for legal proceedings. This could include but may not be limited to certified mail, legal, and/or collection fees.

Additional Terms:
Co-pays are due at the time of service.
Checks returned by your bank are subject to $25.00 finance charge as well as any bank fees incurred.
This office reserves the right to discharge a patient from the practice if the financial policy is not followed.
Please be advised that our practice DOES NOT participate with any Medicare or Medicaid services. If for any reason our practice is unaware that the patient has a primary insurance of Medicaid or Medicare, it is the responsibility of the patient to pay for any services rendered.

Please understand that it is your responsibility to understand your insurance coverage and you are financially responsible for all charges incurred in our office, regardless of what insurance does or does not pay.

I have read and understand the above policy. I give permission for any information regarding my care to be released to my insurance company for payment consideration and to the practice's collection agency partner and/or legal representative should I default on my payment obligations.

I am responsible for my bill regardless of insurance and agree to the above written statements.

I understand that by signing this Financial Responsibility Policy Agreement it authorizes our office or anyone representing this office to utilize all addresses, electronic addresses, and phone numbers (including cellular numbers) available when attempting to contact you regarding payment. It is also agreed that our office may disclose all contact information along with other relevant information to any outside collection agencies used for the collection fees and authorizes them to utilize all information provided to them.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) ____

Responsible party's name (print) ____________________ Relationship ________________

Responsible party's signature ________________________ Date ___________________