FINANCIAL RESPONSIBILITY

CO-PAYMENTS: Due each visit

MEDICARE: We participate and accept assignment with Medicare part B; we will scan your Medicare card for our files. Deductibles that are not met are your responsibility. Patients without secondary insurance are responsible for the 20% co-insurance.

HMO INSURANCES: We will submit charges for HMO insurances; however, co-pay amounts will be collected prior to your appointment. In order to be seen any referrals required by your insurance company must be in our office before or at the time of the exam. Otherwise, you will be responsible for the charges from your visit or your appointment can be rescheduled.

COMMERCIAL INSURANCES: Although we may participate with some third party payment plans, we perceive your insurance coverage as a contract between the insurance company and you. Payment for exam is expected at the time of service. We will assist you by providing appropriate insurance forms for your reimbursement. If deductibles are not satisfied, we will expect payment in full at the time of service.

SELF PAY: Patients with no insurance coverage are expected to pay in full at the time of service using any of these payment options, **CASH, CHECK, MAJOR CREDIT CARDS**.

PATIENT BALANCES: Payment is due upon receipt of statement. Balances not paid within 30 days of initial billing are subject to collections. Should your account be turned over to collections, you will be responsible for all costs of collection and/or attorneys fees.

I have read the above office payment policy and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I have read, understand, and agree to the above office payment policy in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given accurate insurance information to the best of my knowledge for complete and timely payment.

PRINT NAME: ____

SIGNATURE: ____

DATE: ____

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