Financial Policy

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. **Please inform us of any changes to your insurance coverage.**

Please initial each line indicating your understanding of our policies:

____**COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

____**DEDUCTIBLES & CO-INSURANCE:** If you have a high deductible plan, we may collect a **$125** deposit to apply towards your deductible and co-insurance. Any remaining balance after submission to your insurance company is your responsibility.

____**SELF-PAY:** Full payment is due at time of service. A down-payment will be required before seeing the doctor. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/ services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment.

____**REFERRAL:** If your insurance plan requires a referral from your primary care doctor, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

____**NO SHOW:** 24 hours notice is required for cancellation of your appointment and failure to do so will incur a **$50** fee. Failure to provide **24 hours notice** of a procedural visit will incur a **$100** fee.

____**SURGERY CANCELLATION:** Failure to provide **5 business days** notice before surgery will incur a **$500** fee.

____**BALANCES/COLLECTION FEES:** If balance is not collected within 30 days from the postmark date of a mailed statement, a **$12** re-billing fee may be added to each additional statement due to an unpaid balance. Accounts due more than 90 days will be turned over to our collection agency and a **$35** administrative fee will be added.

____**FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$25** charge for having the doctor complete these forms. There is a **$10** fee to obtain a copy of your medical records.

I have read and understand these financial policies.

Patient/Responsible Party Signature:_____

Date: _____ **Printed name:**_____