Patient Financial Responsibility Acknowledgement

OFFICE PAYMENT & FINANCIAL POLICY

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CO-PAYMENTS, DEDUCTABLES AND ESTIMATED CO-INSURANCE: Due at each visit prior to seeing the physician.

REGISTRATION/CHECK-IN: At the time of registration, and periodically thereafter, you will be asked to complete a Registration Form. Thus will help our personnel keep insurance information and demographics accurate. You will be asked to present a photo ID and current insurance card when you check in for your 1st appointment. Any past due balance will be collected at the time of check-in. **Patients under the age of 18 must have a parent or legal guardian in attendance at their appointment.**

INSURANCE: You are responsible for knowing your insurance benefit coverage**.** We will gladly bill your insurance as a courtesy. Deductibles, co-pay's and estimated co-insurance are due at the time of service. Any remaining patient balance responsibility is due prior to the next appointment or within 30 days of receiving treatment. The following forms of payment are acceptable: cash, check, Visa, or Master card. It is the patient's responsibility to determine whether their insurance provider is contracted with our physicians; or considers our physicians to be "in network". Your deductibles or co-pays may be higher as a result if we are ***not*** "in network".

SELF PAY (NO INSURANCE): Full payment is due at the time services are rendered.

RETURN CHECKS: If a check is returned from your bank due to insufficient funds, you will be charged a $25.00 return check fee, plus the original amount of the check. The total of these amounts will be due within 5 business days and must be paid by cash, cashier's check, money order, Visa or Master card. Once a patient has a check returned, no further checks will be accepted.

FORMS/SPECIAL REPORTS (i.e. FMLA, Supplemental Disability Forms, Attending Physician Statements): There is a form fee of $15.00; the fee must be paid prior to the physician completing the forms.

I have read the above Office Payment Policy and as a patient, legal guardian of a minor or impaired patient, I understand that I am financially responsible for payment on my account. I understand deductibles, co-pay's and estimated co insurance are due at the time of service. Any remaining patient balance responsibility is due prior to the next appointment or within 30 days of receiving treatment. I am also aware that **delinquent accounts are subject to other collection means at my own expense including legal fees.**

I have read, understand, and agree to the above **Office Payment & Financial Policy** in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given payment information to the best of my knowledge for complete and timely payment.

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Signature Date