FINANCIAL POLICY ACKNOWLEDGEMENT

We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence. If you have insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy. For the convinence of our patients we offer the following methods of payment of fees.

- Payment in full by cash, bank card, check.
- For insurance patients, we will accept payment directly from the insurance Company only for that percentage the company will cover and do require that the deductible and non-covered fees be paid at time of visit.
- Bank charge cards – Visa, Mastercard, Discover, American Express and bank debit cards are accepted.
- There will be a flat fee of $75.00 per hour for any appointment <u>not</u> canceled within 24 hours of appointment. Our time must be used as efficiently as possible to keep our expenses at a minimum and our fees within reasonable limits.

Our office staff understands insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract. **It is important that you realize, however…**

- Your insurance benefit is a contract between you, your employer, and the insurance company. **We are not a party to that contract**. This office files your insurance claim as a courtesy to you.
- Not all services are a covered benefit in all contracts.

* You (not the insurance company) are responsible to us for all fees for services rendered to you.

- Upon request, a pre-determined estimate of benefits can be given to you.

* We will gladly discuss your proposed treatment and answer any questions you might have as to the involvement of your benefit program in receiving this care. **We appreciate the opportunity to serve you**.

<u>THERE IS NO INTEREST OR FINANCE CHARGE ON CURRENT ACCOUNTS.</u> AFTER 30 DAYS, ALL ACCOUNTS ARE SUBJECT TO A FINANCE CHARGE OF 1.5% OF THE UNPAID BALANCE, WHICH IS AN ANNUAL PERCENTAGE RATE OF 18% (or a minimum charge of $1.00)

Please sign and return to the receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

Signature ____ Date ______________