FINANCIAL POLICY

Insurance

According to your insurance plan, you are responsible for any and all co payments, deductibles and coinsurances. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.

It is a courtesy for our office to file your insurance. If it is denied for any reason, you are responsible for payment in full. It is your responsibility to understand your benefits with regard to covered and non covered services. It is your responsibility to know if written referral or authorization is required for services.

Payment

Self pay patients are expected to pay for services in FULL at the time of visit. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance.

Patient balances are billed immediately on receipt of your insurance plans explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill. We accept cash, checks and most major credit/debit cards.

Fees

If you are not able to keep an appointment, we would appreciate 24 hour notice. There is a charge of $25 for all missed appointments and all NEW patients that give less than a 24 hour notice.

If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a $25 re bill fee for each 28 day cycle. Any balance outstanding longer than 90 days will be forwarded to IC systems collection agency for payment directly to them. You agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 18% of the account balance, and all costs and expenses including reasonable attorney fees we incur in such collection efforts.

A $25 fee will be charged for any checks returned for insufficient funds.

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

Responsible party _____ Date _____