OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care available. In order to achieve this, we need your assistance and your understanding of our payment policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

We realize that temporary financial difficulties may effect timely payment of your account. If such problems do arise, we encourage you to notify us immediately for assistance in the management of your account. If payment arrangements are needed, they must be approved in advance by a member of our staff.

We will gladly discuss your proposed treatment and answer any financial questions you may have. You must realize however, that:

 _____ Your Insurance contract is between you, your employer and the insurance company. We are **NOT** a party to that contract.

 _____ We **DO NOT** accept Assignment of Benefits and we **DO NOT** file insurance, except Medicare. We will provide you with the necessary paperwork to file your insurance and the check will be sent directly to you.

 _____ Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

 _____ Returned checks are subject to a $25 returned check fee.

PLEASE INITIAL BESIDE EACH ARROW TO STATE THAT YOU HAVE READ AND UNDERSTAND EACH STATEMENT.

WE MUST EMPHASIZE THAT, AS MEDICAL PROVIDERS,
OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY.
ALL CHARGES ARE YOUR RESPONSIBILITY
FROM THE DATE THE SERVICES ARE RENDERED.

If you have any questions regarding the above information, please do not hesitate to ask. We are here to help you.

I have read, understand and agree to abide by the above policies.

Signature: _____ Date: _____