OFFICE FINANCIAL POLICY

We are happy you have chosen our office to provide for your healthcare needs. For your benefit, we accept different insurances. As a condition of your treatment by our office, financial arrangements must be made in advance. Our office depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients who carry insurance understand that all services rendered are charged directly to the patient and that he or she is personally responsible for payment of all services rendered. We are happy to submit insurance forms to the insurance company designated. We will also be happy to assist with outstanding claims that need to be resolved. However, we are not the insurance company, and we cannot make the insurance company render payment for services received. It is important for you to understand your insurance policy and what benefits are available to you. We will assist you in any way possible in understanding your benefits. However, ultimately the responsibility for payment on your account is yours. Insurance will rarely pay 100% for services rendered, therefore, please expect to pay your estimated portion at the time of service. We will credit any payment received from the insurance company to the patient's account.

In consideration for the professional healthcare services rendered to me, any member of my family, or any other person at my request, I agree to pay the reasonable value of services rendered at the time services are accomplished, or within five (5) days of rendering services. I understand that I am financially responsible for all outstanding charges whether or not paid by the insurance company. Our office cannot render services on the assumption that the charges will be paid in full by an insurance company. I agree that if payment cannot be made at the time of service, treatment may be denied and I am responsible for any damage incurred. This excludes emergency treatment of pain. At the discretion of this office a payment plan may be available for your portion. All payment plans are in writing and require the execution of a separate document. No oral agreements for payment have been made.

A service charge of 1.75% (21% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service, unless previous arrangements are satisfied. I understand that the fee estimate listed for services prescribed can only be extended for a period of ninety (90) days. After that period, fees and treatments are subject to change at the discretion of this office.

I agree to pay court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee up to 40% of the outstanding balance as compensation to this office for any commission it must pay to a collection agency in collecting any outstanding balance. Furthermore, I agree that this fee is proportionate to the actual damage caused by my nonpayment and is not an excessive estimate of the costs of collection.

I grant my permission to your office to contact me at home or place of business to discuss matters related to this form. I also agree to let this office leave messages concerning appointments on my answering machine or with family members.

I authorize release of all identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to your office, and any collection agency this practice decides to use. I authorize release of information to insurance carriers to collect on my behalf. I authorize payment to come directly to your office.

I understand that there will be a $25 charge on all returned checks. I understand that after one returned check, the only acceptable method of payment is cash or credit card.

I understand a 24 hour notice is required for canceling appointments and that a $30-$50 charge will be made for broken appointments without suitable notice, according to the discretion of this office.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void. I acknowledge that I have received a copy of this office's Privacy Policy (HIPPA agreement) and I hereby agree to abide by the conditions outlined herein.

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Signature of patient, parent or guardian Date