



FINANCIAL POLICY

Thank you for choosing us as your health care providers. The following statement is our financial policy. Your agreement to this policy is required prior to any treatment. The parent or legal guardian is responsible for payment at the time of the visit. Please acknowledge each statement below by initialing on the line

_____ Payments are due at time of service, this includes, self- pay, co-pays, co-insurance, deductibles, non-covered and out of network services.

_____ We accept VISA, MASTERCARD, CASH OR CHECKS. Positive ID is required for all credit card or check payments. There is a \$25.00 fee for all returned checks.

INSURANCE

_____ It is your responsibility to ascertain that your medical provider is a participating provider with your insurance company.

_____ We will bill your insurance directly for services rendered. Patients will receive a statement for any remaining balances after insurance payments.

_____ If we are not in network with your insurance company, you may incur a higher financial responsibility.

_____ A current insurance card and positive identification is required at each visit. Failure to provide the required information will result in forfeiture of the scheduled appointment unless cash or credit card payment can be made for the total charges of the visit.

_____ You are responsible for verifying benefits and coverage prior to any visits so that you are not billed for unanticipated charges. Some insurance companies do not cover some routine and non-routine services. Non-covered services will be billed directly to the patient.

_____ All outstanding balances that have not been paid within 60 days will be billed to the patient and must be paid by 90 days of date of service regardless of the insurance status. **Unpaid patient balances older than 90 Days will be turned over to our collection agency.**

_____ For self-pay patients without insurance, a full payment is required at the time of service.

I have read the above financial policy and understand and agree to its terms and allow the medical providers to treat me.

I _____ have received a copy of this document,
PLEASE PRINT NAME

DATE _____