***FINANCIAL* POLICY**

Patient's Name: _____ Date of Birth: _____

The above named patient agrees to pay for all portions of services due in full at the time services are rendered by our office.

You are required to present a valid insurance card at you Initial visit and as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carries for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointment. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If your insurance carrier has not paid within 60 days of billing, fees are and payable in full from you.

Medicaid: Our office is a Medicaid participating provider and we will bill Medicaid for you.

Methods of Payment:

Our office accepts the following payment methods: Cash, personal check and Patient Financing options for those who qualify.

For returned checks, we assess a $25.00 charge.

If not paid according to the terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay additional fees accessed in the collection of debt. These fees include: collection agency fees and attorney fees.

The patient is ultimately responsible for all fees for services rendered at this office. I have read, understood and agreed to the above financial policy for payments of professional fees.

Signature: _____ Date: _____