

## OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
2. According to your insurance plan, **you are responsible for any and all co-payments, deductibles, and coinsurances.**
3. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
4. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
5. If you have no insurance, **payment for an office visit is to be paid at the time of the visit.**
6. Co-payments and un-met deductibles are due at time of service.
7. Any balance that has not been paid after receiving three statements will be sent to collections if no payment is made.
8. A **\$25.00** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
9. We charge **\$5.00 for the first 5 pages and 0.25 per page after that** to copy or transfer medical records.
10. If you have any FMLA or disability paperwork there is a **\$25.00** charge per form. Payment is due when the forms are dropped off. We have a 3- to 5-day turnaround time for forms.
11. It is your responsibility to know if a selected specialist participates in your plan.
12. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

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

Patient Name(s) \_\_\_\_\_

\_\_\_\_\_  
Responsible party member's name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Responsible party member's signature

\_\_\_\_\_  
Date