



Financial Patient Policies

Billing Policy

Our office will be happy to file your charges for services rendered to your insurance company. If you are a participating member of a managed care plan, we will expect you to pay your co-payment and/or any other fees that are non-covered at the time of your visit. If your insurance is one that we do not participate with or you are a self-pay patient, you will be asked to pay in full for your visit upon check out.

We participate on many plans and it is difficult to always be 100% accurate with the changes that insurance companies make in regard to laboratory work, referral requirements, pre-certifications, etc. We attempt to keep our office staff fully educated to most recent changes and updates. We feel strongly that it is also the patient's responsibility to be aware of how their insurance plans works and your benefit package. Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems your services as non-covered will be billed directly for these charges.

Check Policy & Balances

We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as an NSF (or any other reason), you will be your bill will be assessed a \$25.00 service fee plus the cost of the original check. If you present two checks that are insufficient, then we will no longer accept payment by check on your account. All funds must then be paid by cash or credit card. All patients will be mailed a statement on any remaining balance on their account. The patient will be given 60days to pay the balance in full or make other arrangements with this office. After 60 days this debt will be sent to collections.

Phone Consults

Your insurance will be billed for telephone consultation time with the provider.

No Show Policy

Any time that you miss an appointment in our office without giving any notification, you will be assessed a \$25.00 no-show fee for office visits and \$50.00 for physical appointments. This will be your responsibility to pay and this fee must be paid prior to your next visit.

I have read and hereby understand the above policies.

Signed name by Patient

Date

Print name by Patient

*If you would like a copy of this signed policy, please ask our office manager. Thank you for your business and understanding of this policy.