Billing Policies

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.
On arrival, please sign in at the front desk and present your current insurance card at visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your behalf.

IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances at the time of visit. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
2. 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.
3. 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.
4. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
6. If previous arrangements have not been made with our finance office any balance over 60 days will be forwarded to a collection agency.
7. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remains on file.
8. A **$20.00** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
9. It is your responsibility to know if a selected specialist participates in your plan.
10. 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