



*Treating the **whole person**  
through **focused individual care***

## **PATIENT FINANCIAL POLICY**

We love taking care of you and your family. It is our desire to provide quality medical services at affordable prices. In order to accomplish this, we strive to operate our clinic efficiently.

### **INITIAL VISIT**

Please provide us with current photo ID, insurance card and billing information if you would like us to bill your insurance for you. **All co-pays are due at time of visit.** If no insurance, payment in full is due at time of visit. We accept cash, checks, Visa and MasterCard. **We give 20% discount for full cash payments at time of visit.**

### **HEALTH INSURANCE**

We will bill your insurance company as a courtesy to you. Each insurance company has its own rules for determining how much they will pay on each claim. We will try to answer any questions you have about your insurance, however, your policy is a contract between you and your insurance company. It is your responsibility to know your insurance policy and be familiar with your coverage. **You should contact your insurance company if you have any questions regarding coverage.** If your insurance company denies your claim you are responsible for payment in full. If you do not have insurance coverage, we are sensitive to your individual financial constraints so please discuss this with our billing department.

### **PAYMENTS**

Copays are due at time of service. Unless we approve other arrangements, the balance on your statement is due upon receipt. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts. **We charge 18% annually on accounts over 60 days.** Lack of action on your part will result in your account being sent to an outside collection agency and termination of care from our office. This will adversely effect your credit rating.

### **RETURNED CHECK POLICY**

There will be a \$35.00 fee for all returned insufficient fund checks and payments

### **NO SHOW OR LATE CANCELLATION**

There will be a charge of \$35 for all no shows and late cancellations. This not covered by your insurance.

### **I have read and understand this policy.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient (or Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_