



Payment Policy

This policy explains patient responsibility for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we do business with, payment is due in full after service is completed. It is important that you know your insurance benefits. Please contact your insurance company with any questions you may have regarding your coverage. If you do not have insurance, payment in full is due at the time of service.

2. Co-payments and deductibles. You will be financially responsible for all co-pays and/or deductibles at the time of service, depending on the type of insurance plan you have.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be a non-covered benefit or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit. If you do not have insurance, payment in full is due at the time of service.

4. Proof of insurance. All patients must complete our patient registration form before service is rendered. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. If you are not able to pay the full balance please inquire about payment arrangements. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency if no prior arrangements have been made.

8. Returned check. Our returned check fee is \$30.00. If your check is returned we will require that future payments be made by cash, cashier's check or credit card.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date