Financial Policy

THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR TREATMENT, THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE YOU TO READ AND SIGN PRIOR TO ANY TREATMENT.

ALL PATIENTS MUST COMPLETE OUR PATIENT INFORMATION SHEET BEFORE SEEING THE DOCTOR.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS AND DISCOVER.

REGARDING INSURANCE

WE WILL VERIFY COVERAGE PRIOR TO TREATMENT. AS A COURTESY, WE WILL ALSO PROVIDE YOU WITH A SUPER-BILL AT THE END OF EACH MONTH. OUR FEES ARE DETERMINED BY THE COMPLEXITY OF THE PARTICULAR CASE AND THE DIFFERENT SERVICES USED DURING TREATMENT. ANY BALANCE DUE ON YOUR TREATMENTS IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. WE DO NOT BILL YOUR INSURANCE COMPANY. YOUR INSURANCE POLICY IS CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT PARTY TO THAT CONTRACT. IN SIGNING THIS DOCUMENT, YOU UNDERSTAND THIS OFFICE DOES NOT BILL INSURANCE. ADDITIONALLY IN SIGNING THIS DOCUMENT YOU AUTHORIZE THE RELEASE OF ANY INFORMATION TO ANY INSURANCE COMPANY, ADJUSTOR OR ATTORNEY THAT WILL ASSIST IN THE PAYMENT OF A CLAIM.

USUAL AND CUSTOMARY RATES (UCR)

OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT POSSIBLE FOR OUR PATIENTS. WE CHARGE WHAT IS USUAL AND CUSTOMARY FOR OUR AREA. PLEASE BE AWARE THAT SOME AND AT TIMES PERHAPS ALL OF THE SERVICES PROVIDED MAY BE “NON-COVERED” SERVICES AND NOT CONSIDERED REASONABLE AND NECESSARY UNDER THE MEDICARE PROGRAM AND/OR BY OTHER MEDICAL INSURANCE. YOU ARE RESPONSIBLE FOR PAYMENT IN FULL REGARDLESS OF ANY INSURANCE COMPANY’S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

MISSED APPOINTMENTS

UNLESS CANCELED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS AT THE RATE OF A NORMAL OFFICE VISIT. YOUR TREATMENTS WILL BE MORE EFFECTIVE IF YOU FOLLOW YOUR DOCTOR’S GUIDELINES AND STICK TO YOUR TREATMENT SCHEDULE. PLEASE HELP US SERVE YOU BETTER BY KEEPING SCHEDULED APPOINTMENTS.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE NAY QUESTIONS OR CONCERNS.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

SIGNATURE DATE

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

A PHOTOCOPY OF THIS FORM SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL