FINANCIAL POLICY

PATIENTS WITH COMMERCIAL INSURANCE

I understand that the insurance contract is between the **subscriber and the insurance** company and that this office files to the insurance company as a **courtesy only**.
I understand that it is my responsibility to **know my plan** and that this office cannot be held responsible for any clauses in the contract between the subscriber and the insurance company which my negate partial or full payment to the provider.
I understand that the ultimate responsibility for payment of all services provided by this office resides with the subscriber.
I understand that my insurance may pay less than the actual bill for services, and I agree to be responsible for payment of all services rendered on my behalf or my dependant's behalf.
I understand that any deductibles and/or balances due after insurance will be estimated at the time of service for payment.
I understand that this payment is an estimate only and does not represent payment in full.
I understand that my expected payment will be **collected at the time of service.**
I understand that any outstanding balances which my insurance company **will not cover** will be my responsibility to pay.

PATIENTS WITH NO INSURANCE

I understand that because I have no insurance I am considered a self-pay patient and I must pay the entire bill at the time of service. Any financial arrangements must be satisfied as per the financial agreement.

PATIENTS WITH MEDICAID

I understand that as a Medicaid recipient I must bring a current Medicaid card to each visit, or I will be expected to pay for the visit in full at the time of service.

FINANCIAL OPTIONS

Financial options in office:

- 5% Discount for full patient payment for treatment plans over $2000.00
- Payment Plans (Care Credit) starting at $300.00
- Payment Separation upon selected treatment with doctor approval

ADDITIONAL FINANCIAL INFORMATION

I understand that this office has the right to bill for any **missed or broken appointments at the rate of $35/hour.**
I understand that a **returned check charge of $35** will be applied for any check that is returned
I understand that this office reserves the right to bill finance charges at 1.5% per month on patient balances unpaid after 30 days.
I understand that this office will work to settle outstanding balances.
I understand that all accounts over 90 days delinquent will be turned over to the appropriate collection agency. Should my account be placed for collection, I understand and agree that I will be responsible for all collection cost, court costs, attorney fees and any other fees incurred with the collection of any balances on my account. I understand that this information will be placed on my credit report.
I understand that this office is to be **notified of any changes in your insurance plan before any treatment is rendered.**

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Patient/Responsible Party/ Guardian Signature Date