

# FINANCIAL POLICY

We would like to welcome you to our office and assure you that we are committed to providing the best treatment possible. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

## FULL PAYMENT IS DUE AT THE TIME OF SERVICE

## WE ACCEPT CASH, CHECKS, VISA/MASTERCARD

### REGARDING INSURANCE

We may accept assignment of insurance benefits after your second visit. The balance is your responsibility whether your insurance company pays or not. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance plans where we are a participating provider. All co-pays and deductibles are due at the time of treatment.

If we are not a participating provider we will be happy to provide you with a super bill for you to submit to your insurance company yourself. If you have out of network benefits your insurance company will reimburse you directly.

We DO NOT bill secondary insurances.

### USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

### MINOR PATIENTS

Unaccompanied minors will NOT be seen. All minors MUST have an adult with them for all treatments.

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

### MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

### INTEREST

We reserve the right to charge interest in the amount of 1.5% per month as provided by state law.

Please let us know if you have any questions or concerns. If you need to make other financial arrangements, please see our office manager immediately. We don't want you to forgo treatment due to finances.

I have read the financial policy. I understand and agree to this financial policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patients Representative

\_\_\_\_\_  
Relationship