



FINANCIAL POLICY

INSURANCE

You are responsible for knowing your insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements. You are responsible for providing current and accurate insurance information, including any changes. We will attempt to confirm your insurance coverage in good faith before your treatment. However, you will be financially responsible if claims are denied due to inactive insurance or non-covered services. We will make a copy of your ID and insurance card for our records. Please contact your insurance if you have any questions regarding your insurance benefits.

CO-PAYMENTS, COINSURANCE, AND DEDUCTIBLES

You are responsible for any co-payments, co-insurance, and unmet deductibles set forth by your insurance policy. Insurance requires that we collect these payments from you when services are rendered. We accept cash, checks, and credit cards.

APPOINTMENT: NO-SHOWS AND LATE ARRIVALS

If you cannot make a scheduled appointment, please notify our office at least 24 hours in advance. No-shows and appointments canceled within 24 hours of the scheduled time will incur a \$35 charge. In addition, arriving 15 minutes past the appointment time may result in rescheduling and a \$35 charge. Please understand that this policy is necessary so that we can effectively manage our time to accommodate other patients who need appointments in a timely manner.

FORMS COMPLETION AND OTHER FEES

Unique letters, health-related forms, disability/DMV/jury duty forms, etc.	\$35
Copies of Medical Records	\$35
Returned Checks	\$35

The turnaround time for form completion is 7 days. Rush request (1-day completion) is \$60.

FINANCIAL HARDSHIP

Please let us know before services if you are experiencing financial hardship. We will try our best to arrange a payment plan with you.

You have read, understood, and agreed with the above information by signing below.

Signature: _____ Date: _____

Print name: _____

Check here if you are the patient's Legal Guardian

OFFICE USE

REV'D BY _____