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Office Policy

1. PAYMENT (CO-PAYMENT FOR PARTICIPATING INSURANCE COMPANIES) FOR THE FIRST VISIIT IS DUE IN FULL WHEN SERVICES ARE RENDERED.
2. The fees charged at this clinic may differ from fees charged at other clinics. A schedule of services and fees will be provided upon request.
3. Depending on an individual's insurance coverage, assignment may be accepted. Being put on insurance assignment is a courtesy extended by this office and may be withdrawn at any time.
4. Insurance payment should be received within thirty days. This clinic allows forty-five days. After this time, the amount not paid by the insurance company for the billing period is the responsibility of the patient.
5. In case of more than one insurance carrier, only the primary carrier will be billed by this office. Secondary insurance billing is the patient's responsibility.
6. All insurance forms and information must be in the office within five days of your first visit. If your insurance coverage changes, it is the patient's responsibility to notify the front desk immediately.
7. It will be assumed that a new deductible must be satisfied each new calendar year. If on insurance assignment, the deductible will be assessed to you based on the charges incurred at this office.
8. Patients must stay current with their co-payments if they are on assignments. Patient's share of co-payments is due each visit unless other authorized arrangements are made.
9. If the patient discontinues care for any reason their balance is due and payable immediately; regardless of claims submitted. Any medical information including x-rays will not be released until the bill is paid in full.
10. This clinic will not enter into a dispute with an insurance company concerning payment. This is the patient's obligation.
11. Please call us if you need to cancel / reschedule an appointment.
    a. If a patient misses or does not reschedule without a 24-hour notice, the patient will be responsible for a cancellation fee ($30).
    b. If a patient misses or does not reschedule an appointment without 24 hour notice, the patient will be responsible for the full cost of the appointment.
12. "In the event my account is delinquent and this matter is turned over to my attorney for collection, I agree to pay all costs of collection including but not limited to reasonable attorney fees. I further understand and agree that if any of the services provided to me are not covered by insurance that I am personally responsible for all services rendered." Any payment not received within 30 days of the invoice date will incur a 1.5% service charge until paid in full.

I _________________________ have read and fully understand the above statements.

(print name)

____ __________________________

(signature) (date)