(Practice Name)

[YEAR] FINANCIAL POLICY

Our goal is to help you achieve and maintain optimum health for a lifetime. So that we may better serve you, please read and sign this form. We appreciate the confidence you have place in us as professionals.

We accept cash, personal checks, Visa, and MasterCard as payment for services.

If a check is returned to the office due to insufficient funds, the original check amount plus a $_____ returned check fee must be received within 30 days from the date the check was returned to avoid further late fees or collection action.

Please understand that it is ultimately the patient's responsibility for payment of services. If your insurance company or other benefit program does not cover the entire balance, you are responsible for the remaining amount. Payment is due within 30 days of being notified of the balance unless you have made prior arrangements or have been placed on an extended payment plan. If the balance is not paid within 30 days of notification, your account will be assessed with a $_____late fee.

After a balance has reached 90 days past due, we will turn your account over to an outside collection agency for further action. The patient will be responsible for any charges incurred in such action.

Please be aware that some services provided may be non-covered services under your policy. It is the patient's responsibility to be aware of the individual policy restrictions and guidelines. (Practice Name) will not enter into a dispute with an insurance company, but we can assist you if you are having difficulties.

Note: All laboratory test, injections, venipunctures, procedures, or any testing that is not included as part of an office visit and will result in additional expenses.

Please help us better serve you and our other patients by keeping all scheduled appointments. If you must change an appointment, please do so within 24 hours of the appointment time. The charge is $_____for any missed appointment.

Note: (Practice Name) will only file secondary insurance if you have Medicare as a Primary insurance. We can supply you with any information that you may need so that you can file with your secondary insurance company for reimbursement.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I understand that it is my sole responsibility to verify insurance coverage and I am ultimately responsible for payment in full for any outstanding balances. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform (Practice Name) of any changes associated with my insurance status. Even though I may have health insurance coverage, I understand payment for services is ultimately my responsibility. I understand that payment for service is due at the time that service is rendered unless other financial arrangements have been made.

Patient Signature: _____ Date: _____