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FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our practice is committed to providing the best surgical treatment to our patients. We also feel that by choosing our office, you are making a financial commitment to pay for our services. The following is a statement of our financial policy, which we require that you read and sign prior to your treatment

All accounts need to be paid in full within 6 months from the date of services, unless prior arrangements have been made.

INSURANCE: If you provide us with accurate insurance information, we will be happy to file your primary and secondary insurance claims. We will work with you to obtain any pre-certification your insurance company may require. However, the responsibility for payment falls to you, regardless of insurance coverage or third party liability. As surgical providers, our relationship is with you, not with your insurance company. In compliance with ethical coding guidelines, coding is based on medical findings and are not based on insurance requirements.

USUAL AND CUSTOMARY RATES: We charge what is usual and customary for our area and do not abide by any insurance company's fee schedule. You are responsible for payments, regardless of any insurance company's arbitrary determination of "usual and customary."

COPAYMENTS: All patients are responsible for insurance co-pays at the time of treatment.

DIVORCE CASES: Our policy regarding the billing of an ex-spouse for care of minor children is as follows: We will bill the correct insurance and send the bill to the ex-spouse for payment. However, the final responsibility for the bill will be with the parent who brings the child in for medical care.

COLLECTION ACCOUNTS: If your account is turned over to a collection agency, you will be responsible for all collection fees incurred. You will also be on a CASH ONLY basis for any future treatment.

RETURNED CHECKS: Your account will be charged a \$25.00 service fee for each returned check.

WORKMAN'S COMPENSATION: You Should Be Aware of Your Own Liability! You are responsible for payment if your claim is disputed by your workman's compensation carrier. If your account has not been paid by workman's compensation within 60 days, we will need to bill you directly. If pre-authorization is not received from your claims examiner, we ask that you to pay at the time that you are seen.

EXPENSES FOR CHART COPYING: In accordance with Health Care Act 50-16-540, our office requires a minimum of 72 hours advance notice, a \$15.00 plus \$0.50 per page copy fee, and a signed medical release as required by HIPAA regulations for all charts that are not being sent directly to another healthcare provider. Payment is due when charts are picked up.

Patient Signature: _____ Date: _____

Patient Representative's Signature: _____ Relationship: _____

We also have a credit card payment form, for those patients that wish to pay the balance on their account or use their credit card to set up a monthly payment plan.

This form must be signed before you can see the doctor.

