Our payment policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa and MasterCard.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor-in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, but you are required to pay co-payments and deductibles at the time of your visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Not all insurance plans cover all services. Knowing your insurance benefits is your responsibility. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

5. Payments/Accounts not paid in 30 days will be subject to 1.75% monthly interest. If an outside collection agency is required you will be charged a $25.00 processing fee and be liable for any and all additional cost used to collect our fee.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of patient (or responsible party, if minor) Date

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Please print the name of the patient