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Financial Policy

Thank you for choosing us for your surgical needs. Please read this payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Proof of insurance.** All patients must complete our patient registration form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

3. **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. If a co-payment is not paid at time of service, an **additional fee of $25 will be assessed as a service charge by our office.** If it is a non-urgent visit, we reserve the right to reschedule the visit. Failure on our part to collect co-payments from patients is considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. **Deductibles and Co-Insurance.** Your insurance plan more than likely has an annual deductible and may require co-insurance such as 10% or 20% for certain procedures that you are required to pay. **We will contact your insurance company to estimate these charges before surgery and provide you with a Pre-op Payment Worksheet showing you the estimated charges that need to be paid seven days prior to surgery.** Payment can be made by cash, money order or credit/debit card. Please contact our surgery scheduler if you need options for patient financing. We reserve the right to cancel your surgery if payment is not made within the specified time period.

5. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

6. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Nonpayment.** If your account is not paid within 60 days of the first statement, please be aware that your account will be referred to a collection agency. Partial payments will not be accepted unless otherwise negotiated. An additional fee of $35 will be applied to your account if it is referred to a collection agency.

9. **Returned Checks.** Our policy is to charge $25 for every check that is returned from the bank for insufficient funds or for any other reason that the payment could not be processed.

10. **Missed appointments.** Our policy is to charge $**25 for missed appointments.** You will be charged this fee if your appointment is not canceled within 24hrs. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

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 financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**