Office Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. The policy reduces your out of pocket expense and allows you to place your family under care.

1. **If you do not have insurance:** All payments are expected at the time of service or by an authorized payment plan. Our payment plans make care an affordable part of your family budget.

2. **If you have insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Our payment plans make care an affordable part of your family budget.

   We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

   Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

   When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

   If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

3. **Past due balances:** If your balance becomes more than 30 days delinquent, a late fee of five dollars ($5) will be added to your account. In the event of collection efforts become necessary, you agree to pay all reasonable collection costs, attorney fees and court costs.

By signing this form, you are acknowledging that you have read, understand and agree to comply with the above mentioned policies. You also understand that you are assigning your insurance benefits to us rather than paying out of pocket for all services at time of service.

Patient's Printed Name: _____ **Date:** _____

Signature: _____