Patient Financial Responsibility

Your Financial Responsibility

You are financially responsible for the services we provide to you. We understand that many patients arrange for insurance companies to pay for a large portion of medical claims. However, the patient is ultimately responsible for the bill if the insurance company does not pay.

We provide two billing related courtesies to our patients:

1. We will contact your insurance carrier to request a pre-authorization/pre-determination for any planned treatments, if required by your insurer. It is important to understand that even if the insurance company provides authorization for treatment, it does not guarantee that they will pay once services have been performed.

   For this reason, we strongly recommend you contact your insurance company directly to confirm what degree of payment you can expect from them based on your individual plan, and to confirm that any planned procedures are included in the plan you chose.

2. We will file a claim to your primary and secondary insurance plans.

All payments are due at check-in.

Expect to pay at the date of service; co-payments, coinsurance, deductibles, non-covered services, etc. If you are unsure of your financial responsibility, please contact your insurance company in advance, to obtain this information.

Any balance remaining after insurance has paid their part of the covered portion will be due prior to the next appointment.

Missed appointments and no-shows

As a courtesy to our patients, we will call to remind you in advance of your upcoming appointment. Our staff will contact you at the telephone numbers you have provided 24-72 hours prior to your scheduled appointment.

A fee of $30 will be assessed to your account if 24 hour advanced notice is not given. This fee is not covered by insurance carriers or Medicare and will be your responsibility to pay at the time of your next visit. A 24-hour notice of cancellation provides us with the ability to schedule patients on our wait list. Your cooperation and consideration are appreciated with regards to this policy.

Prior Balance
Patients with a prior balance at the time of service will be asked to pay the prior balance in full before being seen.

Methods of payment
We accept cash, check, VISA, MasterCard, and Discover. We do not accept post-dated checks, nor will we hold checks for any length of time.

Returned check
There will be a $30.00 fee assessed for any check returned from the bank for any reason.

Information change
Please advise us of any address, phone number, or insurance changes promptly. Failure to do so may result in your insurance company not being responsible for your care and you will subsequently be held responsible for paying out of pocket.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form.

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Print Name Signature of Patient/Responsible Party Date