



## Payment Policy and Financial Agreement

We are committed to providing you with the best possible care. If you have medical insurance we are eager to help you receive the maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

- Payment for all copays, deductibles, and non-covered office services and supplies is due at the time service is rendered, unless payment arrangements have been approved in advance through the business office. If payment is not made upon checking out of the office, *a \$15 fee will be applied.*
- We accept cash, checks, MasterCard, American Express and Visa (returned checks are subject to additional services charges and bank fees).
- We are happy to submit a claim form to your insurance carrier, but we require appropriate proof of insurance, ID number, and mailing address at each visit. If such information is not provided, full payment will be expected from you.
- When we are a non-participating provider with your insurance carrier, we require payment in full at time of service, and we will submit a claim on your behalf. If the carrier remits payment to us, we will promptly reimburse you the appropriate amount.
- If your insurance carrier requires you to obtain a referral or precertification prior to receiving our services, it is your responsibility to be aware of and to obtain such requirements.
- Surgical procedures may require a deposit, including deductible and/or co-pay. Remaining balances are to be paid within one month of settlement with your insurance company (unless arrangements for pre-payment or a monthly payment schedule have been made in advance.) We pre-approve the surgical procedure with individual insurance carriers to determine benefits, but it is ultimately the patient's responsibility to pre-approve all surgical procedures and to be aware of conditions of approval, such as obtaining second opinion, etc.
- *Effective January 9, 2001, any appointment not kept or cancelled less than 24 hours prior will be subject to a \$25 charge.*

Important: Some plans require patients to obtain referrals and/or preauthorization for services provided at outside facilities (hospitals labs, radiology, etc.) Occasionally, a provider may send a patient to these facilities directly from the office. In such instances, the patient must notify our business office within 24 hours so that they may obtain the necessary referral or preauthorization. *If we are not notified, and subsequently unable to obtain a referral or preauthorization, you will be responsible for the bill.*

Other notes about insurance:

- Medical insurance is a contract between you, your employer and your insurance company. We are not a party to that contract unless we have chosen to be a participating provider with the insurance plan.
- Our fees fall within a range based on the level and standard of care provided, in this regional area, and are covered up to an allowance determined by each carrier. Some carriers pay on the basis of a percentage of this usual, customary and reasonable range (UCR), and others pay on an arbitrary fee schedule, which bears no relationship to UCR. Our fee reduction is based on the prevailing Medicare Allowable, Region 1 area, participating provider rate. These fees are available in our business office for review.
- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover, and regardless of our practice participation with a plan, payment for any non-covered services will be the patient's responsibility.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. We cannot be responsible for any loss of benefits. It is your responsibility to know your policy. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.

I have read and understand this financial arrangement and realize that all fees, regardless of the insurance coverage, are ultimately my responsibility.

---

Patient Signature

Date

I HEREBY AUTHORIZE THE RELEASE of any medical information necessary to process the direct payment of medical benefits to the named provider. I have read and understand the attached financial agreement and realize that all fees, regardless of insurance coverage, are ultimately my responsibility.

---

Patient Signature

Date