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Credit and Collection Policy Statement

1. On arrival, please present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.

2. According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances. Copayment is due at the time of service. If payment is not received within 10 days, a nominal billing surcharge may be applied to your account.

3. We do not submit to secondary insurance plans. If you have a secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.

4. It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see specialist, if preauthorization is required prior to a procedure, and what services are covered.

5. It is your responsibility to verify that our providers participate with your particular insurance plan. If our physicians do not participate in your plan, payment in full is expected from you at the time of your office visit. For scheduled appointment, prior balances must be paid prior to the visit.

6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.

7. A $20.00 fee will be charged to your account for NSF checks that are returned by the bank. After two NSF checks have been returned on your account, we will request payment by cash or credit card only.

8. If a personal balance is due after insurance has responded for a date of service, a statement will be sent to the responsible party. Payment in full is expected upon receipt of the first statement. **Please do not disregard any statement you receive from our office.** Please call our billing department if you have any questions or feel that there are any error.

9. It is understood that if your account is turned over to a collection agency, you will be responsible for any collection costs that are incurred.

10. As a courtesy to our office and to other patients, we ask for as much notice as possible when cancelling any appointments, including sick and follow-up appointments. For all late cancellations or no show appointments, there is a charge that will be applied to your account.

11. There is a nominal fee for each camp/sports form processed. Fee is payable at time of drop-off.

Patient Name : _____Signature : _____Date : _____

Other authorized person(s) to contact, or speak to regarding billing/insurance issues:

Name : _____Relationship to Patient : _____

Home # : _____Cell # : _____Work # : _____