

## Office Policy and Financial Agreements

Payment in full is due at the time services are rendered unless other arrangements are made in advance. For your convenience we accept **Visa, MasterCard, Discover, and American Express**. Additional office staff, postage, paper and time is needed to bill patients which increases costs. To keep costs down and make health care affordable for everyone, we do not bill our patients. We reserve the right to suspend care on balances over \$100. At this time a payment must be made in order to continue receiving care.

An insurance policy is a contract between the insured and the insurance company. However, we will assist you by filing your primary insurance as a courtesy for you. You will be responsible for filing any secondary insurance if you have any. You agree to pay your deductible, co-pay or co-insurance at the time services are rendered.

Minors under the age of 18 with scheduled appointments must be accompanied by a parent or legal guardian. A finance charge will be added to all accounts 30 days past due. A service charge for RETURNED checks will be added to the account in the amount of \$39.00 for each occurrence. Any outstanding account balance 90 days or older with no activity will be turned over to a collection agency or Magistrate court. It will be your responsibility to pay for any and all collection fees or court costs.

Any outstanding account balance not covered by your insurance company will be your responsibility.

If you have any questions we will be glad to answer them for you. We will be glad to arrange a financial arrangement if necessary prior to initiation of treatment.

Time is valuable for both you and us. If a confirmed appointment is broken, there will be a \$100.00 broken appointment fee. We make every effort to assist you in making a convenient appointment. If you must cancel, please notify us 24 hours PRIOR to your scheduled appointment to avoid the broken appointment fee. If an appointment has been scheduled, please try to be at least five minutes early, since ample time has been set for your treatment. If you are TEN minutes late, your appointment may be rescheduled

**THANK YOU,**

By signature, I have read and understand the office policy of this practice. In cases where payments are being accepted directly from the insurance company, I authorize payment to the provider.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date