

Office Policies

Because we commonly have a waiting list, **we have a \$25 charge for missed appointments or for a cancellation with less than 24 hours notice.** Additionally, if you are going to be more than 15 minutes late, please provide us with a courtesy call as this will hold your appointment and you will not incur a charge for a missed appointment. Please help us serve you better by keeping your scheduled appointments so we can better serve you in a timely, professional manner.

Financial Agreement

Regarding Insurance:

As a service to you, our billing office will gladly bill your insurance company directly on a bi-weekly basis. Our billing office will also bill supplemental insurance and secondary insurance companies. In order for us to perform this service for you, please provide us with the necessary information specified below:

- If you are using health insurance, we will need to obtain a copy of your insurance card, as well as the assignment of benefits form filled out (located in new patient paperwork). **Each patient is responsible for meeting their deductible and paying co-insurance/co-payments according to their insurance plan at the time of service.**
- If you have no insurance coverage, or if we are unable to verify medical benefits, we offer a discounted cash option at the discretion of the provider. Payment is due in full at the time of service.
- **To better serve you, we require a credit card to be on file with our office. This card can be used for co-pays and/or co-insurance amounts, secure your appointment date & time, or can be used as a backup should you forget to bring your method of payment on your treatment date.** This option allows us to take care of any charges for you without having to reschedule your appointment.

Credit Card Type _____ **Card #** _____

Exp Date _____

Assignment of Benefits

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of information acquired in the course of my treatment, including but not limited to medical records, electronic and oral communications, to my insurance company representatives, employer, primary care physician, referring MD, and/ or other third party payer.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns at any time.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature _____ **Date** _____

Printed Name _____