

Thank you for choosing us as your health care provider. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Our office participates with a variety of insurance plans. ***It is your responsibility*** to:
  - Bring your photo ID and insurance card to every visit.
  - Be prepared to pay your co-pay at each visit. Payment can be made by cash, check or credit card.
  - For medical care not covered under your insurance, you may be required to pay ***in full at the time of visit.***
- If we do not participate in your insurance plan, our office will file your claim upon request; ***however, payment in full may be required at time of service.***
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. If you fail to provide this information, you may be financially responsible.
- Financial assistance may be available if you are unable to pay for necessary medical care. It is your responsibility to inform us that you are unable to pay prior to your visit.
- It is your responsibility to bring any referrals or authorizations required by your insurance for treatment ***at, or prior to, the visit.*** If you do not have a necessary referral or authorization, your visit may be rescheduled, or you may be financially responsible.
- If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for bringing his/her insurance card and any necessary referrals or authorizations, and for making any payment due at time of service.
- If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (the phone number is typically on the back of your insurance card).

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the physician's office. ***Please sign that you have read and agree to this Financial Policy.***

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Signature of Patient or Responsible Party

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Date

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Signature of Co-Responsible Party

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Date