

## **Financial Policy**

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate in discussing them with us.

### **Your insurance**

We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

If your insurance coverage changes, it is your responsibility to notify our office at least 24 hours before your next appointment. Failure to do so may result in rescheduling of your appointment and a \$25.00 cancellation fee. In addition, we may not be a provider with your new insurance. You will then be treated as a cash patient and given a superbill in order to file your own claim.

You may receive a separate bill from an off-site laboratory (Ameripath, Freeman-Cockerell, LabCorp etc) for any lab tests your physician may order. Please discuss any lab billing discrepancies with that laboratory.

With the exception of our Medicare patients, we DO NOT file secondary insurance.

### **Missed Appointments**

Please call us as early as possible if you know that you will need to reschedule your appointment. **Please note:** There will be a missed appointment and/or procedure fee charged for any appointment and/or procedure missed without 24 hour prior notification.

### **Returned Check Fee**

There will be a \$25 charge for all returned checks.

**Collections:** If your account is turned over to our collection agency, you will be responsible for the collection fee charged us by the agency in addition to your outstanding balance.

**I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.**

\_\_\_\_\_  
**Signature of Patient or Responsible party**

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Date of Birth**