Sample Financial Policy

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

If you do not have insurance, we expect payment in full for all treatment at the time of service unless other arrangements have been made. We accept cash, checks, VISA and MasterCard.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. Your insurance claim will **ONLY** be completed and submitted if we are provided with all pertinent insurance company information. It is ***your responsibility*** to verify that your policy is in force on your date of service. Otherwise, you are responsible for payment at the time of service.

Insurance is an agreement between you and your insurance company. We file insurance claims as a courtesy to you, our patient. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances, "usual and customary" charges, etc., other than to supply necessary factual information. **Deductibles and co-payments are required at the time of service. You are responsible for the prompt payment of your account.** If payment is not received from your insurance company within 90 days, the balance on the account becomes your responsibility.

AGREEMENT

You agree, in order for us to service your account or to collect monies you may owe, that we and/or our agents may contact you by telephone and/or text message at any telephone number associated with your account, including wireless telephone numbers. We and/or our agents may also contact you by email using any email address you provide. Methods of contact may include the use of pre-recorded voice messages and/or the use of an automated telephone dialing system as applicable.

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that a monthly finance charge of 1.5% may be added to my account if my balance is not paid in full within 30 days. I understand and agree that my account may be turned over to a collection agency after 90 days and that a 25% collection fee will be added to my account.

Responsible party signature________________________________ Date____________