FINANCIAL POLICY

Our main concern is personalized, quality care for our patients. We pride ourselves in offering the most up-to-date, specialized treatment in our field. In order for us to provide the highest quality care with today's rising healthcare costs, we established a financial policy for our patients.

For patients without insurance we ask that payment be made in full at the time of service. For procedures that require multiple visits or incur lab costs, every effort will be made, based on the information your insurance company provides us over the phone, to let you know what your **approximate** co-payment will be on the day of your procedure.

Your insurance will be submitted for you as a **courtesy** within two days of treatment. If your insurance pays more than your account balance, a refund will be issued to you. If your insurance pays less than anticipated, you will be sent a statement for the unpaid balance.

Each insurance company has a schedule of fees which they will pay. Our fees may be more or less than the schedule of your insurance company; therefore, **YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY OUTSTANDING BALANCE**. You will continue to receive monthly statements until your account is paid. If your account is not paid in full within (90) ninety days, it will be considered delinquent. After (120) days from treatment, delinquent accounts will be turned over to a professional agency for collection. ***IN ADDITION, CHARGES RELATED TO THE COST OF COLLECTION (INCLUDING BUT NOT LIMITED TO, COLLECTION AGENCY FEES, REASONABLE ATTORNEY FEES, AND COURT COSTS) WILL BE ADDED TO YOUR ACCOUNT.

INSURANCE DISCLAIMER

The information we obtain from your insurance company at your appointment is done as a **courtesy** to you. Although every effort is made to obtain the most accurate information, each insurance company provides us with a verbal disclaimer stating,
*****BENEFITS QUOTED ARE NOT A GUARANTEE OF PAYMENT*****
We therefore, cannot be held responsible for any discrepancy between the estimated benefits we give to you as given to us by your insurance company, and the final payment or lack thereof which your insurance ultimately makes.

I have read, fully understand, and accept the financial policies of this practice.

____/________________
Responsible Party Signature Date