WELCOME TO OUR OFFICE

"Dedicated To A Higher Quality Of Life"

OUR OFFICE POLICY

FINANCIAL ARRANGEMENTS

OUR OFFICE POLICY

We **WELCOME** you to our office and assure you that you will be receiving the very best care available.

The fees charged in our office are comparable to those charged by other health care providers in this area, with similar qualifications.

Health and accident policies are an arrangement between you and your insurance company. All services will be charged directly to you and you will be personally responsible for payment.

FOR PATIENTS WITH NO INSURANCE
It is customary to pay for professional services when rendered. We ask that you pay for your 1st visit with cash or check.

We realize it may be inconvenient to make payments at the time of each office visit, therefore, our office manager will be happy to help you with a **WRITTEN FINANCIAL AGREEMENT.**

FOR PATIENTS INJURED ON THE JOB (Worker's Compensation)
Your employer is responsible for any costs in treating your work related injury, including attorneys fees, if necessary. IF YOUR INJURY IS WORK RELATED BE SURE AND TELL US BEFORE STARTING TREATMENTS.

FOR PATIENTS WITH INSURANCE
As a courtesy we will accept your insurance assignment, as soon as your coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

If you were involved in an auto accident, we will bill the medical insurance portion of the insurance policy of the vehicle in which you were riding. If you are the owner of the vehicle, we will bill your own insurance company.

If you were a passenger in someone else's car, we will bill the driver's insurance company. If you were a passenger in a vehicle which was not insured, but you own a car which has medical coverage, the insurance company which carries your policy will be responsible for your medical bills.

If you were involved in a slip and fall type of accident, we will bill the responsible party and/or your attorney.

Since by taking your insurance on assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it. If you discontinue care without our authorization, the balance of your account is due and payable in full immediately, even if your insurance has been filed.

Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.

We will bill your insurance on 30 day cycles as long as you are receiving care in this office.

You should pay the percentage of your responsibility as you go along (e.g. if your insurance pays 80% of your care, you should pay 20% on each visit.)

All checks received from your insurance company will be promptly credited to your account. If there is an overpayment we will send you a refund, or send the check to you if you have already paid your bill. If there is still a balance owed, we will bill you for the balance.

You will be required to sign an "Authorization to Pay" form and any other assignment or lien forms required by your insurance company on your 1st visit.

Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

We ask that you please notify us 24 hours in advance if you cannot keep your appointment.

If you have any questions please feel free to discuss them with our office manager.

THANK YOU *for coming to our office for your health care. You and your health needs are our chief interest and concern.*

(over)

FINANCIAL AGREEMENT

I am receiving (or about to receive) health care services in this office and understand that I am directly responsible for all my health care bills submitted by this office for services rendered.

This agreement is made solely for the providers protection in consideration of having to wait for payment for these services, providing that there continues to be a reasonable probability that payment will be made, either by insurance proceeds or out of the settlement of a liability.

I have read and fully understand my responsibility concerning the payment of services rendered.

Patient Signature _____
(OR PARENT, IF A MINOR)

Date Signed _____

Witness Signature _____

OFFICE MANAGER:

PHOTOCOPY THE BACK OF THIS PAMPHLET AFTER THE PATIENT HAS SIGNED AND DATED IT.

RETURN THE PAMPHLET TO THE PATIENT, AND PUT THE COPY IN THE PATIENTS RECORDS.

Copied & filed by _____

printed on recycled paper.

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