FINANCIAL AGREEMENT

INSURANCE:
Every policy is different and regardless of any participating provider status there are some policies that limit the reimbursements paid to us. **It is each patient's responsibility to be familiar with their insurance coverage. Any insurance claims not paid within 90 days is your responsibility. Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you. Although we estimate what your insurance company might pay, it is the insurance company that makes the final determination of payments made on your behalf. Any balance remaining for services is your responsibility.**
If your insurance company requires a referral and/or preauthorization, our staff would be happy to assist you with this but ultimately you are responsible. This means it is your responsibility to know the limitations associated with your insurance policy. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from your insurance company.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. The amount shown as your balance is due immediately.

PAYMENT OPTIONS:

- Estimated amounts not covered by insurance are due when the services are rendered or in some cases prior to treatment been rendered. There are no exceptions unless pre-arrangements have been made.
- We accept the following forms of payment: Cash, Check, Visa and MasterCard.
- In addition, we offer Care Credit, a patient payment program offering a full range of No Interest and Extended Payment Plans. Care Credit is a third party lender and we are not associated with Care Credit in any way.

A LATE FEE of ten dollars ($10) per month may be applied to accounts that are not paid within twenty-five (25) days of the statement date.

A FINANCE CHARGE will be imposed on each item of your account that has not been paid within ninety (90) days of the time the item was added to the account. The finance charge will be computed at a Monthly Percentage Rate of 0.8% or at an Annual Percentage Rate of 10.5%. You also agree to pay all attorney fees and costs of collection incurred if your account is not paid as agreed.

A RETURNED CHECK fee of $25.00 will be applied to your account for any check that is not cleared through the bank.

CREDIT BALANCES AND REFUNDS: Occasionally an insurance company will pay more than we estimated. If this occurs we will issue you a refund. If you have a credit balance less than $15.00 it will remain on your account for future treatment unless you contact us to request a refund.

WORKERS COMPENSATION/PERSONAL INJURY: We require full payment up front unless other arrangements have been made prior to your appointment.

CREDIT HISTORY/WAIVER OF CONFIDENTIALITY: You give us permission to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. You understand that if this account is submitted to an attorney or collection agency, if we litigate in court, or if your past-due status is reported to a credit reporting agency, any treatment received at our office may become a matter of public record.

DIVORCE: In case of divorce or separation, the party responsible for the account initially remains responsible for the account afterwards. The parent authorizing treatment for a child will remain responsible for any subsequent charges. If the divorce decree requires the other parent to pay part or all of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

PATIENT'S NAME _____ DATE _____

PATIENT OR GUARDIAN SIGNATURE _____