Our Financial Policy

Insurance/Secondary Insurance

Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot
Guarantee coverage due to complexities of insurance contracts. Your estimated portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full. If you have any questions, our courteous staff is always available to answer them.

No Insurance

For all services we expect the balance paid in full the day of service by cash, check or charge.

Divorce Decrees

This office is NOT a party to your divorce decree. All adult parties are responsible for their bill and at the time of service and the adult accompanying their child to the visit is responsible for their child's bill.

Minor Patients

A parent or legal guardian must accompany all minor patients. The parent or legal guardian accompanying minor is responsible for their child's bill.

Appointments

Your scheduled appointment time has been reserved especially for you. We request 24 hour notice if you need to cancel you appointment. We are aware that unforeseen events sometimes require missing an appointment. After missing your second appointment without notifying us 24 hours in advance, you are subject to being charged an additional fee of $50/per hour.

Returned Checks

All checks returned will be charged a $25 returned check fee for non sufficient funds.

Collections

In the event you account is turned over to an attorney or agency for collections, or suit is
Brought on, or the account is collected through any judicial proceeding whatsoever, the undersigned shall pay all reasonable costs of collection, including attorney fees, agency fees, court costs and finance charges (up to 50%) incurred to our office to enforce payment.

Thank You for understanding our Financial Policy. Please Sign the Financial Policy with understanding that you have read and understand it fully.

Name of patient_____

Name of responsible party_____
Signature of responsible party_____**Date**_____