Patient Name: ____________________ Acct No: _________ D.O.B. _________

Patient Financial Obligations

1. Co-payments must be paid at the time of your visit. We accept cash, checks and credit card payments.
2. There will be a $25.00 fee charged for all checks returned to us due to insufficient funds.
3. You are responsible for any charges incurred as a result of your visit.
4. Your claim will be processed through your insurance company(ies) provided that we have ALL the accurate and complete information.
5. It is your responsibility to obtain a referral from your primary care physician prior to your visit, if your insurance requires one.
6. If you do not provide us with a referral prior to your visit, we reserve the right to reschedule your appointment.
7. We will assist you with obtaining pre-authorization for any scheduled surgeries.
8. If your insurance company fails to pay your bill within 90 days, the bill will be transferred to you.
9. If you fail to make prior arrangements with us and your account balance extends beyond 90 days in arrears, your account will be turned over to a collection agency.
10. You are responsible for any treatment, supplies, etc. that your insurance does not cover.
11. If you have no insurance, payment is expected at the time of service.
12. Medicare is accepted, however a co-payment is required unless you have a secondary insurance.
13. We participate in many managed care plans, however it is your responsibility to verify coverage of benefits with your insurance company prior to your visit.
14. A minimal fee of $10.00 is charged for completing any disability forms.
15. If your insurance company requires you to use a specific laboratory and/or facility, it is your responsibility to notify us.
16. Patients under the age of eighteen will not be seen unless accompanied by a parent/guardian, unless we receive a signed authorization from the parent/guardian, which allows the physician to provide medical treatment. (The only exceptions to this would be a minor who is seeking Contraceptives, Pregnancy testing, Sexually Transmitted Diseases and HIV, Sexual Assault and Emergency Care.)

Please ask if you have any questions about your financial obligations.

______________________________ ______________

Signature of Patient/Guardian Date