Patient Financial Policy

We have instituted the following financial policies. **All patients and/or beneficiaries must read and understand all sections before being seen by any provider**. These policies allow us to avoid passing increased operational costs on to you, our patient. Please familiarize yourself with our policy.

1. Patient Responsibility

- You are ultimately responsible for your medical bills.
- Insurance coverage does not guarantee payment.

2. Appointments

- Cancel or reschedule at least **24 hours in advance**.
- Missed appointments without 24 hours notice may incur a **$30 - $50 no-show fee**.

3. Payment at Time of Service

- **Uninsured patients:** Payment is due at your visit.
- **Insured patients:** Co-pays, deductibles, and co-insurance are due at your visit.
- Incorrect insurance information may result in a **$10 administrative fee** for resubmitted claims.

4. Medicaid Patients

- Bring a valid Medicaid card to every visit.

5. Cosmetic Services

- Full payment is required at the time of service.
- Payment arrangements are **not available** for cosmetic services.
- Addition fees may be incurred for non-payment of cosmetic services on the date-of-service.

6. Late Payments & Collections

- Accounts **60+ days past due** may incur finance charges: **$5 or 1.5% per month (18% APR)**.
- Returned checks: **$30 fee**.
- Accounts sent to collections: **35%–50% recovery fee**.

7. Insurance Verification

- We will bill **primary and secondary insurance carriers** as a courtesy.
- You are responsible for providing **accurate insurance information** and confirming with your insurance carrier that we are a participating provider.

8. Contact & Questions

- Keep your contact and insurance info current.
- Our billing staff is happy to help with questions or payment arrangements.

Acknowledgment

- By receiving services from our providers, you acknowledge and agree to this financial policy. If you choose to proceed with your visit, this policy will be enforced regardless of whether the form is signed**.**

_____	_____	_____
Signature	**Print Name**	**Date**