OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance my not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do accept secondary assignment and will file any unpaid services to your secondary insurance. The balance remaining after filing to both parties is complete will be considered your responsibility.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within 90 days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your frequency of care is once per month or less, there is a possibility that your insurance company will not cover your treatment. If this occurs, you will be considered a cash patient and follow the terms for not having insurance. If there is an exacerbation of your condition and/or your frequency increases, please notify the front desk of these changes. We may then try to file those charges to your insurance company for potential reimbursement.

If you discontinue care for any reason other than discharge by the doctor, all balances become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: ____

Signature: ____ Date: _________________

Finance Counselor: ___________________________________ Date: _________________

For your convenience you may retain your credit card number on file with us.

Card #: _____________________________________ Expiration Date: ______________

Name as appears on card: ____