



Thank you for choosing us as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but you have copays or deductibles, payment in full is expected at each visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
2. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
3. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
4. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
5. **Late appointments.** Our policy is to reschedule your appointment if you are more than 10 minutes late. You will be subject to a missed appointment fee (\$25). Please help us to serve our patients timely by showing up to your appointment on time.
6. **Missed appointments.** Our policy is to charge for missed appointments (\$25) not canceled with at least 24 hours' notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
7. **Surgery cancellations.** Our policy is to charge for any surgeries cancellations (\$250) once appointment is made. Your request for surgery requires multiple person hours to coordinate. These charges will be your responsibility and billed directly to you.
8. **Paperwork.** Our policy is to charge for any paperwork (\$25) that needs to be filled out by the physician or office staff. This fee is to be paid up front when paperwork is dropped off or called in to be filed online. The charges will be your responsibility and billed directly to you.

By signing below, you also understand that any charges not covered by your insurance for durable medical equipment (**DME**) will be your responsibility and billed directly to you.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

#### HIPAA Privacy Rule

In accordance with the HIPAA Privacy Rule, when Protected Health Information (PHI) is to be used or disclosed for purposes other than treatment, payment, or health care operations, the Facility will use and disclose it only pursuant to a valid, written authorization, unless such use or disclosure is otherwise permitted or required by law. Use or disclosure pursuant to an authorization will be consistent with the terms of such authorization.

I have read and understand the payment policy and agree to abide by its guidelines:

\_\_\_\_\_  
Signature of Patient / Responsible party

\_\_\_\_\_  
Date