

Financial Policy

Patient Name: _____ **Date:** _____

The completion of information/ insurance forms represents an administrative service to our patients above and beyond the provision of medical care. The time and effort involved in providing this detailed information results in significant cost to our practice. In order to keep your insurance and financial arrangements as simple as possible, we ask you to adhere to the following policies:

1. The refusal of insurance companies and requesting agencies to cover the cost requires us to institute a policy for the completion of forms as follows:
 - a. **\$25.00** per form for completion of the following
 - i. Credit card deferment form
 - ii. Family Medical Leave Act Forms
 - iii. Private Disability Insurance Form
 - iv. School Educational Disability/ Limitation Forms
 - b. **\$50.00** for completion of any dictated letter which describes medical care and limitations that is additional to a copy of a document already in the medical record.
 - c. **\$100 - \$250.00** for any narrative report detailing diagnosis, treatment and future medical care that is additional to a copy of a document already in the medical record.
2. You are ultimately responsible for payment of charges for services you receive from our practice. We gladly accept cash, MasterCard/Visa and checks. However, any check dishonored by your bank will result in a \$75.00 returned check charge being added to your account.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan. **If you see a health care provider that is NOT currently on your plan, you will be responsible for payment in full.**
4. All co-payments will be collected upon arrival for your visit.

I have been given and understand this financial policy. I agree to adhere to it.

Patient Signature _____ Date _____
(Parent if minor)