Financial Responsibility Agreement

Legal Name: _____ Date: _____

We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

Insurance: We accept assignment and participate in mostly all insurance plans. If your insurance is not a plan we participate in, payment plans are available. Knowing your insurance benefits is your responsibility. Please contact your insurance with questions you may have regarding your coverage to receive the maximum benefit.

Patient payment: Per the arrangement with your insurance company, all copayments and deductibles are expected to be paid. For your convenience we accept cash, checks or credit cards (i.e.; VISA, Mastercard, Discover and American Express) ****There is a $35 fee for all returned checks****

Self-Pay patients: Payment plans and/or discounts are offered to our patients who do not have insurance. Please let us know if financial assistance is needed.

Forms: There is a flat $5 fee for completing each disability, FMLA, sick leave, and AFLAC form.

Claims: We will submit your insurance claims and assist you in any way we reasonably can to help get them paid. However, your insurance company may not accept information from our office and may need additional information from you. You are required to provide any information they need.

Missed appointments: It is our goal to give you the best care possible. You can help us serve you better by keeping your regularly scheduled appointment. In the event you are unable to make your appointment, please allow us 24hr notice.

Thank you for you understanding our financial policy. Please let us know if you have any questions or concerns.

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SIGNATURE OF PATIENT OR PARENT/GUARDIAN