Statement of Patient Financial Responsibility

Patient Name: _____

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. For patients without insurance, a consult fee is due at the time of appointment.

No Show / Cancellation

Please give at least 24 hour courtesy notice if you are unable to keep your appointment. Failure to do so will result in a $25 missed appointment fee.

Returned Checks

Any check returned by the bank will be charged a $25 returned check fee in addition to fee for service rendered to cover charges we incur.

Acknowledgement

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

Printed name: _____

Date of birth: _____

Signature of patient / guardian _____

Date: _____