FINANCIAL POLICY

Our goal is to maintain a good physician–patient relationship through clear communication. Please review this policy carefully and initial each section.

Financial Responsibility Initials: _____

- You are responsible for all co-payments, deductibles, coinsurance, and non-covered services as determined by your insurance plan.
- Co-payments are due at the time of service.
- Self-pay patients must pay in full at the time of the visit.
- Balances are due within 10 business days after receiving your bill.
- Accounts unpaid after 90 days without arrangements may be sent to collections.
- We accept cash, checks, Visa, and MasterCard.
- A $25 fee applies to returned checks.
- If you have trouble paying, please contact us promptly—payment arrangements may be available.

Insurance Initials: _____

- We bill your insurance as a courtesy; however, payment is ultimately your responsibility if your insurer does not pay due to inaccurate/untimely information or claim denial.

No-Show & Late Cancellation Policy Initials: _____

- If you cannot keep this or any other appointment, please advise us as early as possible.
- If you do not call to cancel or re-schedule your appointment within 24 hours of the appointment time, you may be charged $50.00.
- We reserve the right not to reschedule patients who have multiple cancellations.

Acknowledgment

I have read, understand, and agree to comply with this policy. I accept responsibility for any balance due.

Patient Name: _____ Date: _____

Responsible Party Signature: _____

****"A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."**