Your Choice®
Primary Care

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Payment is expected at the time of service. We accept cash, check, major credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. Please be advised that physician copayment(s) does not include lab tests, radiology, or pharmacy.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered by the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- All charges for treatment become due and payable sixty (60) days after the date of service. These period will allow sufficient time to process insurance and make payment in full of any remaining balance. In the event you submit payment by check and the bank returns the check unpaid for any reason, $25 fee will be added to the original balance. If not paid within 60 days, various collection activities will be initiated including but not limited to submitting the past due account to a collection agency.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- If you are scheduled for a new patient appointment or an annual preventive visit (routine physical), but other significant health concerns are addressed as well, insurance guidelines mandate the visit be coded for preventive visit and evaluation & management visit, and you will be responsible for any applicable copayment(s). Each and every visit is billed as required by insurance, and you will be responsible for any applicable copayment(s) regardless of the reason for the visit.
- Although we call to confirm appointments as a courtesy, it is ultimately the patient's responsibility to keep the appointment. if you are unable to keep the appointment, please notify us at least 24 hours prior to your appointment date. Failure to do so will result in $25 fee being charged to your account per occurence.
- Please understand that failure to keep the account balance current may require us to cancel or reschedule your appointment.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party	Date
Name of Patient/Responsible Party	Relationship to Patient