# FINANCIAL POLICY AND BILLING PROCESSES
## Please read and sign below

1. **Payment Due**: I understand that payment is due when service is rendered.
2. **Co-pay, Co-insurance and Deductibles:** It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service. If your plan has a high deductible, please be aware that you will be required to make a prepayment towards your deductible at the time of your visit.
3. If I am not able to pay my co-pay, deductible or co-insurance portion at the time of service my appointment may be rescheduled.
4. **Insurance Coverage**: I acknowledge that the insurance cards I have presented are current and accurate.
5. **Non-covered Services**: I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
6. **Denied Charges**: I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carriers deem them payable or not and that I am obligated to pay for these services in full.
7. **Participating Insurance Plans:** If the practice is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
8. **Returned Checks & Past Due Accounts:** Returned checks will be subject to collection charges, penalties and interest. All accounts are considered past due if not paid within **30 days** of service. Past due accounts may result in collection turnover and subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept post dated checks.
9. **CHIPS (Children's Health Plan):** I understand that the practice participates in the CHIP program for **medical conditions only**. The practice **does not** participate in CHIPS vision plan. If no medical diagnosis is found, even if I were referred by another physician, I will be responsible for all charges.
10. **Medical Plans that have Vision Benefits**: Please be advised that some medical plans do have routine vision benefits; however, sometimes these vision benefits are with a different carrier than your medical plan. We may be participating providers with your medical plan but not your vision plan. Please contact your carrier to verify your benefits.
11. **No Show Appointments:** All appointments that are not cancelled within 24 hours of appointment time are subject to a $50.00 no show fee. This $50.00 fee must be paid before we can reschedule your appointment. All surgery/office procedure appointments not cancelled within 1 week of the scheduled appointment will be subject to a $250.00 cancellation fee and for cosmetic surgeries $500.00
12. **Surgery Charges:** The practice will make every effort to determine your insurance benefits and to relay to you what you will owe for surgery charges, please keep in mind that this is just an estimate. Please be aware that when surgery is performed, you may incur additional charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory or radiologist. All payments are due one week prior to surgery.
13. **Authorizations**: Some insurance plans require you receive prior authorization for services by a specialist, please review your policy to see if there is such a requirement and obtain this authorization prior to your visit with our clinic.

**Patient Signature:** **Date:**

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***If you would like a printed copy of the financial policy, please inform the receptionist.**