

Financial Policy

Insurance Participation

We participate in most major insurance plans. If you have any questions regarding insurance and your healthcare coverage, please call your insurance provider, which is listed on the back of your insurance card, or contact us to verify coverage prior to your appointment.

Third Party Payers

We will file your regular medical insurance if we participate and bill you according to insurance company instructions. We will file to a Workman's Compensation policy but **REQUIRE** the following information be provided at the time of the initial treatment: Workman's Compensation company name, claims mailing address, adjuster name, adjuster phone number and claim number.

Eligibility Information

We will ask for your insurance card(s) at each appointment. If you do not have your current insurance card(s) and necessary information, you will be required to pay for the services rendered or asked to reschedule your appointment.

Claims Filing

We will file claims for those insurances with which we are contracted, as well as secondary insurance if we participate with your primary insurance. We accept the contractual write-off based on your primary insurance. Once we have received instruction from your insurance company, you will receive a bill for any outstanding balance. **If we are unable to file your claim because of incorrect insurance, patient demographic, or guarantor information and you do not provide the correct information timely, then we will not file the claim for the service, but will treat the visit as a self-pay visit and you will be responsible for 100% of the visit costs.**

Non-covered services by insurance payer

Patient will be responsible for all services that is non-covered by your insurance company.

Payment

We accept Checks, Cash, Visa/MC, AMX, Discover and Debit cards. All payments for service are due on the day the service is provided.

Alphaeon Credit

We accept Alphaeon Credit as a form of payment for services rendered. We are required to follow the Alphaeon Credit Operating Guidelines which stipulate: the card holder must be present with the card and must provide 2 forms of valid ID.

Co-Pays

Many plans require that a patient pay a co-pay at each visit. We are bound by our contracts with insurance companies to collect that co-pay at the time we render our services. In keeping with our contracts, we will collect your co-pay when you check in.

Appointments and No-Shows

We ask that all patients arrive 15 minutes early for their appointment. We understand the unexpected that may cause a patient to arrive late and we will accommodate your arrival time as best we can. However, if you arrive 15 minutes beyond your appointment time it will be rescheduled. **The following fees apply to no-show visits:** \$75 for missed appointments. \$100 for a missed in-office procedure and/or surgery. We require a 24-hour advance notice of cancellation so that we may offer that appointment to another patient. After 3 no-show appointments within a 12-month period you will be discharged from our practice and will be required to seek medical care from another practice.

Patient Refunds

Any over-payment made by the patient will be applied to any outstanding balance. If there is a remaining credit after outstanding balance is satisfied, it will be refunded to the patient.

Small Balances

You will not receive bills for balances less than \$3. However, we will notify you of the balance at your next visit and expect payment.

Returned Checks

We charge a \$30 fee for returned checks. Patients who have written a returned check will be required to pay by cash or credit for all future payments.

Bankruptcy

Accounts written off due to bankruptcy will also result in termination from our practice. However, you may work with your Bankruptcy attorney to draft a letter expressing your intent to pay our bill and continue as a patient.

Charge for Medical Records

Medical records requested will be copied for a flat fee of \$12.00 + 75¢ per page 1-25, .50¢ per page 26-100, .25¢ per page over 100.

Forms

If forms are filled-out by your provider, there is a \$25.00 fee for completion of these forms.

By signing below, I agree that I have read the above financial agreement. I understand and agree to adhere to the policies included within the agreement.

Patient/Guarantor Name: _____

Patient /Guarantor Signature: _____ Date: _____

Relationship to Patient: _____