

Financial Policy and Cancellation Notice

- Payment is due prior to services being rendered on or before the day of your scheduled appointment for cash patients. Insurance co-payments are also due at the time services are rendered for patients with insurance.
- As a courtesy to our patients, we will happily file your insurance for you. Please remember that your insurance coverage is a contract between you and your insurance company; therefore, you are responsible for full payment of your account when due. If your insurance is denied after the initial filing for whatever reason, you are responsible for paying our office in full for the amount due. We will only file your insurance claim once on your behalf and after that it is your responsibility to handle the dispute of a denial with your insurance company.
- Confirmation calls are considered a courtesy to our patients, but they are not guaranteed. It is the patient's responsibility to keep track of their scheduled appointment times. We will do our best to try to reach you prior to all appointments, but it not guaranteed or required by our office to do so.
- A \$25.00 No Show Fee will be charged for all cancellations or rescheduled appointments without a 24 hour notice given to our office, regardless of receiving a confirmation call. This fee must be paid prior to the next scheduled appointment date.
- Due to increased postage, printing costs and dedicated staff time, we will only send you three statements prior to referring your account to a collection agency if payment is delayed. We would much rather work with you directly; so please be prompt in paying your bill or contacting us if you need to make a payment arrangement. A convenience fee will be added to all outstanding balances if a payment arrangement is made. If payments are late, the patient is responsible for an additional 1.5% late fee.
- We are happy to accept cash, checks or credit card, or help you with a financial arrangement through Care Credit.

I have read and understand the above financial policy and cancellation notice and agree to adhere to the conditions set forth in the above.

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Name of Patient – Please Print

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Date

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Patient/Guardian Signature