**Office Policy**

Patients with HMO or POS Plans

* A valid referral must be presented prior to your appointment and patients are responsible for payment in full if the proper paperwork is not on file.
* It is the patient’s responsibility to keep track of authorized visits to our office.

All Patients

* All patients’ under 18 years of age must be accompanied by a parent or legal guardian.
* Minors not accompanied by a parent or legal guardian will not be seen.

Prescription Refills

* Before calling our office for a refill, please check with your pharmacy to see if any refills are present. We require 48 hours notice if a prescription is needed.
* If your insurance company requests a 3 month mail in order, please allow ample time for the order to be received through the mail. The patient is responsible to mail in prescription.

Medical Records and Forms

* Written authorization from the patient/parent or guardian must be obtained to release medical records.
* One week’s notice is required to complete your request for medical records and/or completion of forms.
* A $20.00 processing fee applies to the above requests.
* A DVD of patient Digital X-Rays will be provided at patient’s request for a fee of $10. A printed copy will

be provided for a fee of $20.

No Show and Cancellation Fee

* A 24 hour cancellation notice is required for all appointments. A $25 fee may be implemented if required notice is not given.
* If you are 15 minutes late for your appointment you will have to reschedule and if you miss three (3) appointments we will no longer be able to schedule appointments for you.

**PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED AND A FEE OF $30.00 WILL BE CHARGED FOR ALL RETURNED CHECKS. IT IS THE RESPONSIBILTY OF THE PATIENT TO NOTIFY OUR OFFICE OF ANY INSURANCE AND/OR DEMOGRAPHIC CHANGES.**

 *Office Policy subject to change without notice.*

I have read and understand the Office Policy and agree to abide by its guidelines.

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient/responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Policy**

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy that will become effective immediately. Please read it and ask any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. Insurance: We participate in most insurance plans, including Medicare. If you are insured by a plan we are not contracted with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you have regarding your coverage.
2. Co Payments: All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments can be considered fraud. Please help us in upholding the law by paying you copayment at each visit.
3. Non Covered Services: Please be aware that some and perhaps all of the services you receive may be non – covered or not considered reasonable or necessary by Medicare or other insurers. In this event the balance in this event the balance is the responsibility of the patient.
4. Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct information in a timely manner, you may be responsible for the balance of the claim.
5. Claim Submission: We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If they have not paid within 60 days the balance will be billed to you. Your insurance benefit is a contract between you and your insurance company, we are not party to that contract.
6. Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. Billing: This office is contracted with PCMG for billing services. Questions regarding your bill should be direct to them. If your bill is not paid within a reasonable amount of time, it may be turned over for collection. You will be responsible for all collection cost.
8. It is our policy that the parent or legal guardian who accompanies a child to our office for treatment is responsible

for payment of all services rendered.

*Payment Policy subject to change without notice.*

*All payments & copayments are due at time services rendered.*

I have read and understand the payment policy and agree to abide by its guidelines.

Print patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_