



FINANCIAL POLICIES

The purpose of this policy is to encourage our patients to take their appointments and healthcare as seriously as we do. When we book you an appointment that time is reserved specifically for you and the time that your health requires. We plan longer appointments to provide you with great care, while still receiving the same insurance payments for shorter visits. Because of this, we ask you to please remember that if you cancel with short notice or do not show for your visit, we are unable to offer your spot to those on a waiting list.

When necessary appointments can be made if you need paperwork filled out / signed by the provider. Examples include but are not limited to: disability forms, handicap plate requests, redoing forms already completed, insurance wellness incentives or physical validations for work/school, communication or letters to attorneys, landlords etc. If you choose to forgo the appointment to discuss this paperwork it can be mailed in or dropped off to be completed for an administrative / **paperwork fee of \$30**, as you may find this more convenient and cheaper than your copay. Please notify us in advance regarding your plans and deadlines so we can determine if we have / schedule the time needed to complete the forms in a timely manner. Please note that there is no guarantee that your insurance will pay this fee, or that you will be satisfied with the materials provided if you choose not to attend a visit.

The fees for missing or cancelling an appointment with less than one full working day notice are \$100.00 for new patient appointments (as they are scheduled for longer blocks of time since they are more involved) and \$50.00 for established patient appointments.

Returned payment / insufficient funds will result in a **fee of \$25** in addition to the balance originally due. If you need accommodations for a payment plan to pay for an appointment or resolve a balance, please call to make arrangements. If you know you will not be able to pay for your portion of a visit, payment plan options should be discussed with the financial coordinator in advance so biweekly or monthly payments can be scheduled to keep your account in good standing.

We encourage a credit card be stored on file so in the event you have an appointment balance that goes unpaid for 3 monthly billing cycles and your claim hits collections status, a payment plan can be initiated for you. Our in-office payment plan will split your balance due in half and your card on file will be charged 1/2 of the balance plus a \$5 fee for the next 2 months required to settle the balance. To avoid these fees and the automatic payment policy please pay attention to your statements and call with questions. You can mail, call in or go to the portal to make payments, or call the office to set up a more convenient payment plan if needed. We offer this option to avoid having claims sent to an external collections agency where an additional \$50 fee will be added to the balance due and delinquency may be reported to credit agencies.

Excessive disregard of these policies may jeopardize future appointments with our practice. We understand that unforeseen crises may arise and a fee may not apply. Please call us to explain the circumstances as we remain available to discuss this policy for individual cases. We will consider each circumstance and your history to determine if a fee will be reduced or waived. Please note that any cancelations for “convenience” or last-minute “schedule conflicts” will be assessed this fee. Also, as we are a medical practice so most often we are comfortable with you coming in when sick, especially since we may be able to help you with your concerns.

All Fees and prior balances should be paid in full prior to any subsequent appointment being scheduled. These are personal fees and are not paid by insurance and are therefore not subject to self-pay or cash discount. Thank you for your understanding and agreeing to our policy as indicated by your signature and initial below.

Patient Name _____ **DOB** _____

Signature Patient / Guardian _____ **Date** _____

*Initial if **agreeing** or **declining** to keep a card on file to be billed automatically for unpaid balances more than 3mo old as outlined above, to avoid being sent to an outside collections agency.