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Payment Policy

We appreciate your confidence in our practice and we look forward to participating in your care. We realize that most medical problems are not foreseen; therefore, we wish to advise you of our payment policy.

1. We will file all insurance for your care. You will be responsible for all co-pays, co-insurance and deductibles at the time of visit.
2. All self-pay patients will be expected to pay in full on their first visit.
3. We will submit to all patients (2) statements of current patients balance by mail. If we receive no response to these statements, we will begin the collection process immediately. If your account is sent to an outside collection agency, you will be responsible for all collection and legal fees.
4. We encourage you to stay in contact with our office regarding financial issues, as we will attempt to work with you.
5. We accept MasterCard, Visa, American Express, Cash and Check.
6. Returned Check fee is $25.
7. If you cancel your appointment in less than 24 hours or ‘No show’ for an appointment, you may incur a $30 fee.

I have read and understand the above payment policy.

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Patient’s Name

______________________________ ______________________________
Patient’s Signature Date