Financial Policy

Thank you for choosing us as your health care provider. The physicians and staff are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. This statement of Financial Policy must be read and signed by you prior to any treatment. Furthermore, all patients must complete the Patient Information Form before seeing the physician.

All co-pays, deductibles and co-insurance are due at the time services are rendered.

We accept cash, checks, Visa, Mastercard, Discover and American Express.

Insurance Coverage:

The balance on your account is still your responsibility whether your insurance company pays or not.
We cannot bill your insurance company unless you give us your insurance information.
Your insurance policy is a contract between you and your insurance company.
If your insurance company has not paid your account in full within 60 days from the date services are rendered, the balance will automatically be transferred to your responsibility.
Please be aware that some, and perhaps all, of the services provided by the physician, a P.A. (Physician's Assistant), or other licensed professional may be non-covered services and not considered reasonable and necessary under your medical insurance.

Due to recent problems with insurance coverages, you must inform us if your insurance or your PCP (Primary Care Provider) changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

No Insurance Coverage:

If you do not have insurance coverage, you are expected to pay to your acccount in full before any medical procedures are performed. We accept cash, checks, Vis, American Express, Visa or Mastercard. If you are unable to pay your account in full at the time services are rendered, we will accept a payment schedule as follows: 50% in advance, 25% due in 30 days from the date of the procedure, and the remaining balance due in 60 days. (If your bill is $100.00 or less, then the balance is due in full.)

I, _____, have read the above information and agree
Print your name here
with the terms of the Financial Policy.

Signature: _____ ***Date:*** _____