



Financial Policy

As a courtesy to our patients, we will accept "assignment of benefits" from insurance carriers and will bill your insurance carrier for you. To do this, we must be provided with complete insurance information.. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service.

If you are a self-pay patient without insurance coverage, all fees are due and payable at the time services are rendered unless prior arrangements have been made with our billing department.

If you are a parent of a minor, it is the responsibility of the parent who is seeking treatment for the child to ensure that payment is rendered accordingly.

It is also the parent's responsibility to understand their insurance coverage, so we encourage all parents to contact their insurance company prior to treatment. Before being seen, we will verify coverage from your insurance carrier.

All co-payments and deductibles are due up front and payable by check, cash or credit card. Any check returned by your bank for any reason, will be assessed a \$25.00 return check fee which will be added to your account and must be paid in full by either cash or credit card prior to any follow up visits.

By signing below I understand that I am responsible for the payment of services provided. If for any reason I am delinquent in my payments, I will be responsible for the cost of collections and possibly incur an interest rate up to 1.5% a month on an overdue bill. I acknowledge receipt of the financial policy and a copy shall remain in my child's chart.

Parent/Guardian Signature

Date

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____